CHILD/ADOLESCENT CLIENT HISTORY

Child's Name_____Date of Birth_____Date_____

Person Completing Form_____Relation to Child_____

Primary Care Dr._____Other Dr. Treating Your Child_____

1. The Family-List yourself and all members living in the home including your child.
   Name Sex Age Place of Work or School
   _____
   _____
   _____
   _____
   _____
   _____
2. If there have been any parental separations or divorces, give date(s), name(s) of other parent figures, and list which parent(s) has legal and which has physical custody of your child.
   _____
   _____
   _____
3. Family Members not living with you (for example, grown children).
   _____
   _____
4. At what age did your child: walk_____ say single words_____ fully toilet trained_____
   ride a bicycle_____ write his/her name_____ read 20-30 words_____
5. Were there any difficulties with your child's birth, infancy, or preschool development?
   _____
   _____
   _____
6. List any medical problems which your child currently has_____
   _____
   _____

7. List any medications which your child takes often (include vitamins, birth control pills, and non prescription drugs._____
8. List any surgeries, major injuries, or illnesses your child has had_____

   _____
9. Does your child smoke, drink alcohol, or use other drugs? _____
10. Does your child have trouble with sleep? _____
11. Does your child have any eating or weight gain problems? _____
12. Are there any family members (parents, siblings, grandparents, aunts, or uncles, cousins) who have had emotional, mental health, or substance abuse difficulties? (Include behavior or school problems, seizures/epilepsy) _____

    _____

    _____
13. Has anyone in your family ever seen a counselor or doctor for emotional, mental health, or substance abuse difficulties? If yes, what and when? _____

    _____

    _____
14. Has anyone in your family ever taken any medications for emotional, mental health, or substance abuse difficulties? If yes, who and when? _____

    _____

    _____
15. Has anyone in your family ever been in a hospital for emotional, mental health, or substance abuse difficulties? If yes, where and when? _____

    _____

    _____
16. Has anyone in your family attempted suicide? _____
17. How does your child get along with other his/her age? _____

    _____
18. How does your child get along with others in the family? _____

    _____
19. How does your child do in his/her school work? _____

    _____
20. Has your child been in special education? If yes, when and for what reason? _____

    _____
21. What other things would be helpful to know about your child or your family?