

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?