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Diplomate of the American Board of Psychiatry and Neurology

Child, Adolescent & Adult Psychiatry

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Child Psychological History

Date of Appointment: _____

Name of person filling out form:_____ Relationship to patient:_____

Patient Name:_____Sex:_____Age:_____Date of Birth:_____

Social Security #:_____School: _____ _____ Grade: ____ Teacher: _____

Home Address:_____City: _____ Zip: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email: _____ Referred By:_____

Reason for Referral:_____

Litigation pending?_____ Attorney:_____Phone:_____

History of Present Problem

How long ago did problems begin: _____

Please describe the problems that you want help with:_____

Psychiatric History

Place a check to indicate if any problems apply currently (in the last six months) or in the past.

Current	Past		Current	Past	
☐	☐	Suicidal thoughts (date?_____)	☐	☐	Homicidal thoughts (date?_____)
☐	☐	Depression/sadness	☐	☐	Anxiety/nervousness
☐	☐	Recurrent/intrusive thoughts	☐	☐	Recurrent/intrusive disturbing recollections/dreams
☐	☐	Loss of appetite	☐	☐	Overwhelming need to perform certain behavior/rituals
☐	☐	Weight loss	☐	☐	Excessive fears or phobias
☐	☐	Overeating	☐	☐	Significant concerns with physical problems
☐	☐	Weight gain	☐	☐	Poor frustration tolerance
☐	☐	Difficulty sleeping	☐	☐	Explosive anger
☐	☐	Apathy	☐	☐	Rapid mood changes
☐	☐	Fatigue	☐	☐	Euphoria (feel on top of the world)
☐	☐	Loss of interest in almost all activities	☐	☐	Racing thoughts
☐	☐	Feeling worthless	☐	☐	Decreased need for sleep
☐	☐	Feeling hopeless	☐	☐	Aggressive
☐	☐	Poor self-esteem	☐	☐	Visual or auditory hallucinations
☐	☐	Sexual problems	☐	☐	Stomach aches
☐	☐	Anorexia or Bulimia	☐	☐	Bizarre behavior
☐	☐	Unmotivated	☐	☐	Shy and withdrawn
☐	☐	Dependent	☐	☐	Self-mutilates
☐	☐	Quiet	☐	☐	Self-stimulates
☐	☐	Resists change	☐	☐	Exhibits sexually inappropriate behavior
☐	☐	Wetting bed or clothes	☐	☐	Risk taking
☐	☐	Bowel movements in underwear	☐	☐	Is cruel to other people
☐	☐	Emotional	☐	☐	Swears a lot
☐	☐	Immature	☐	☐	Steals things without people knowing several times
☐	☐	Is very fidgety	☐	☐	Often runs away from home and stays away over night
☐	☐	Can't remain seated	☐	☐	Easily lies to others
☐	☐	Can't wait his/her turn when playing with others	☐	☐	Fire setting
☐	☐	Answers before she/he hears the whole question	☐	☐	Doesn't go to school
☐	☐	Rarely follows other's instructions	☐	☐	Breaks into other people's property
☐	☐	Destroys other people's property	☐	☐	When fighting, has used a weapon
☐	☐	Is cruel to animals	☐	☐	Starts fights with others
☐	☐	Other unusual behavior:_____			

___

Indicate which stressors your child is experiencing currently (within the last 6 months) or in the past.

Now	Past		Now	Past		Now	Past	
☐	☐	Death of spouse	☐	☐	Illness of family member	☐	☐	Illness of friend
☐	☐	Personal injury/illness	☐	☐	Parents separated	☐	☐	Parents divorced
☐	☐	Conflicts with family	☐	☐	Conflicts with friends	☐	☐	Conflicts at school
☐	☐	Academic Difficulties	☐	☐	Change in residence	☐	☐	Legal problems
☐	☐	Sexual Assault	☐	☐	Incest/sexual abuse	☐	☐	Physical abuse
☐	☐	Verbal/emotional abuse	☐	☐	Other problems:			

Is your child currently receiving therapy?_____ From who?_____
When did your child start therapy?_____For what problems(s)?_____

_____
List current psychiatric medications:_____
Has your child received therapy in the past?_____From who?_____
When (Start and finish):_____For what problem(s)?_____

_____
List past psychiatric medications:_____
Has your child been hospitalized for psychological problems?_____When?_____
Where was your child hospitalized?_____

Has your child ever attempted suicide?_____When?_____ How?_____

Has your child had a prior psychological or neuropsychological evaluation? Yes ___ No ___ If yes, complete this information:
Name of psychologist: _____
Address: _____
Phone:_____ Date of and reason for this evaluation:_____
Findings of the evaluation: _____

Substance Use History

Current Past (Even if only occasionally or in small amounts):

- ☐ ☐ Alcohol
- ☐ ☐ Tobacco How Much? _____ How Often? _____ When did your child quit? _____
- ☐ ☐ Marijuana
- ☐ ☐ Barbiturates ("Downers")
- ☐ ☐ Tranquilizers
- ☐ ☐ Amphetamines ("Speed")
- ☐ ☐ Crank
- ☐ ☐ Crack
- ☐ ☐ Cocaine
- ☐ ☐ Opiates (Heroine, Opium, Codeine, etc.)
- ☐ ☐ Hallucinogenic (LSD, STP, "Magic Mushrooms", etc.)
- ☐ ☐ PCP ("angel dust")
- ☐ ☐ Ecstasy
- ☐ ☐ Other: _____

DOCTOR'S NOTES

Birth and Developmental History

Place of Birth:_____ Were parents married at time of birth? _____
Was mother under a doctor's care during the pregnancy? _____Was the child adopted?_____ If so, at what age?____

Check any illnesses during pregnancy:
☐ Anemia ☐ Toxemia ☐ Herpes ☐ Measles ☐ German measles ☐ Bleeding
☐ Kidney disease ☐ Heart disease ☐ Hypertension ☐ Abdominal trauma ☐ Infection ☐ Diabetes

Medications taken during pregnancy:_____
Were drugs or alcohol taken during pregnancy? ☐ Yes ☐ No If yes, specify:_____
Was there significant emotional stress during pregnancy? ☐ Yes ☐ No If yes, name stressors: _____

Was the birth: ☐ On time ☐ Premature (By how long) _____ ☐ Late (By how long): _____
Was labor: ☐Spontaneous ☐ Induced Duration of labor__ (Hours) ☐ Cesarean required ☐ Cesarean planned
Was the presentation: ☐ Normal ☐ Breach ☐ Transverse (Crosswise) ☐ Posterior first
Did the baby experience any of these problems: ☐ Fetal distress ☐ Prolapsed cord ☐ Low placenta (Placenta previa)
☐ Premature separation of the placenta (Abruptio placenta) ☐ Cord wrapped around neck
Any other problems that mother or child had: _____ Was general anesthesia used: ☐Yes ☐No
Were forceps used? ☐Yes ☐No Were there breathing problems? ☐Yes ☐ No
Color at birth: ☐ Normal ☐ Blue ☐ Yellow Was oxygen used ☐ Yes ☐ No (How long)? _____APGAR Score ___
Birthweight: _____ Length:_____

Check those that apply to the first few weeks after birth:
☐ Excessive sleeping ☐ Laziness ☐ Irritability ☐ Excessive crying ☐ Stiffness ☐ Limpness ☐ Tremors
☐ Twitching ☐ Feeding difficulties ☐ Vomiting ☐ Jaundice Other:_____

Transfusions required? ☐Yes ☐No (Why)_____
Medication required? ☐Yes ☐No (Why)_____
Surgery required? ☐Yes ☐No (Why)_____

Give approximate ages that developmental milestones were achieved:
Head control _____Rolled over_____Sat alone _____Walked _____Run _____
Said first word ____Used sentences _____Self feeding w/ utensils _____ Toilet trained _____
Dress self _____ Tie shoes _____Color within lines _____First menstruation or beginning of puberty:_____

Check any problems that occurred in later development:

☐ Hearing ☐ Speaking ☐ Stuttering ☐ Reading ☐ Writing ☐ Spelling ☐ Arithmetic
☐ Behavior ☐ Hyperactivity ☐ Seizures ☐ Coordination ☐ Attention difficulties

List family members with developmental or learning problems:_____

DOCTOR'S NOTES

Medical History

Please check all the conditions that have been diagnosed.

- ☐ AIDS, ARC or HIV
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Abscessed ears
- ☐ Arteriosclerosis
- ☐ Bleeding disorder
- ☐ Blood disorder
- ☐ Broken bones
- ☐ Brain
- ☐ Cerebral palsy
- ☐ Colds (excessive)
- ☐ Chicken pox
- ☐ Carbon monoxide
- ☐ Cancer
- ☐ Diabetes
- ☐ Enzyme deficiency
- ☐ Encephalitis
- ☐ Ear Infections
- ☐ Fevers (104 or higher)
- ☐ Genetic disorder
- ☐ Head injury
- ☐ Heart problems
- ☐ Hereditary disorder
- ☐ Headaches
- ☐ Hearing problems
- ☐ Huntington's disease
- ☐ Hypertension
- ☐ Hormone problems
- ☐ Hazardous Substance
- ☐ Immune system
- ☐ Jaundice
- ☐ Kidney problems
- ☐ Liver disorder
- ☐ Lung disease
- ☐ Lead poisoning
- ☐ Leukemia
- ☐ Metabolic disorder
- ☐ Meningitis
- ☐ Measles
- ☐ Mumps
- ☐ Malnutrition
- ☐ Multiple sclerosis
- ☐ Oxygen deprivation
- ☐ Pneumonia
- ☐ Poisoning
- ☐ Polio
- ☐ Parkinson's disease
- ☐ Rheumatic Fever
- ☐ Radiation Exposure/Therapy
- ☐ Scarlet Fever
- ☐ Senility (Dementia)
- ☐ Stroke or TIA
- ☐ Tuberculosis
- ☐ Tumor
- ☐ Thyroid disease
- ☐ Venereal disease
- ☐ Vision problems
- ☐ Whooping cough
- ☐ Other medical/physical problems: _____

Has your child ever been diagnosed with epilepsy or a seizure disorder? ☐ Yes ☐ No

If yes, check the one they have been diagnosed with.

PARTIAL
- ☐ Simple partial
- ☐ Complex partial
- ☐ Partial evolving into generalized

GENERALIZED
- ☐ Absence (Petit mal)
- ☐ Myonclonic
- ☐ Clonic
- ☐ Tonic
- ☐ Tonic-clonic (Grand mal)
- ☐ Atonic

☐ UNCLASSIFIED

Medication and dosage:

List any medications currently being taken (over-the-counter or prescription), and the dosage

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

List any medications your child is ALLERGIC or sensitive to: _____

Past Hospitalizations (When, where and for what):

_____
_____
_____
_____

Outpatient Surgeries (When, where and for what):

_____
_____
_____
_____

Name of family physician: _____
Address: _____
Phone: _____ Date of your last medical check-up: _____

Medical Testing

Check all medical tests that recently have been done and report any abnormal findings:

	Check here if normal	Abnormal findings
☐ Angiography	☐	_____
☐ Blood work	☐	_____
☐ Brain scan	☐	_____
☐ CT scan	☐	_____
☐ EEG	☐	_____
☐ Lumbar puncture or spinal tap	☐	_____
☐ Magnetic Resonance Imaging (MRI)	☐	_____
☐ Neurological office exam	☐	_____
☐ PET scan	☐	
____		
☐ Physician's office exam	☐	_____
☐ Skull x-ray	☐	_____
☐ Ultrasound	☐	_____
☐ Other testing:_____	☐	_____

DOCTOR'S NOTES

Family History

Father's Name _____ Age _____ Health Problems _____
Education _____ Occupation _____ Employer _____
Mother's Name _____ Age _____ Health Problems _____
Education _____ Occupation _____ Employer _____
Date of parent's marriage _____ Years married _____ Current marital problems? _____
If separated, give date _____ If divorced, date _____
Previous marriages? (Father) _____ (Mother) _____Subsequent marriages? (Father) _____ (Mother) _____
If divorced, current custody arrangement _____

Please provide information regarding step-parents if your parents are divorced:

Name	Age	Education	Occupation	Date Married	# Years

Names and ages of brothers and sisters (Include step-brothers and step-sisters):

_____
_____
_____
_____

List anyone else who lived in the home during your childhood: _____

List names of any biologically related family members (E.G. Immediate and distant relatives) with any of the following problems:
Alcohol Abuse _____
Criminal History: _____
Emotional/behavior problems: _____
Medical problems (e.g. Heart disease, Cancer, Seizures) _____
Learning/developmental problems: _____

DOCTOR'S NOTES

Social History

How long has she/he lived in the current home? _____Apartment or house? _____How long in this town? _____
How many changes in residence in child's lifetime? _____ Ages moves occurred? _____
What towns have he/she lived in the past? _____
How many friends does your child have in your neighborhood? _____ First name of best friend in neighborhood: _____
How often does he/she play with neighborhood friends? _____ Any conflict problems (What type)? _____
What are his/her most frequent play activities? _____
How many friends does he/she have at school? _____First name of best friend at school? _____
Is your child well liked/accepted at school? _____Any conflict problems (What type)? _____
List clubs and organizations that he/she is involved in: _____
_____
Is your child involved in a church? _____ Denomination: _____Attend how often? _____
What time/activities do you share with your child? _____
Please describe your last vacation (when & where): _____

DOCTOR'S NOTES

Educational History

Current grade (Or highest grade/degree completed): _____ Current school: _____
Past schools attended (List in order): _____
Hardest subject(s): _____ Favorite subject(s): _____
Grades earned in elementary school: _____ Junior High G.P.A. _____ High School GPA _____ College GPA _____
Grades repeated: _____ Learning problems (what subjects): _____
Special education placement (Type): _____ During which grades: _____
Extracurricular activities (Music, Sports, Clubs, etc.) _____
Expulsions/suspensions/conduct problems (Type of problem and date): _____
Additional schooling or non-academic training: _____

DOCTOR'S NOTES

Occupational History ☐ Not Applicable

Present employer: _____ Position: _____
Length of employment: _____ Hours worked per week _____ Current responsibilities: _____

List previous employment (Include dates and type of work):

_____

_____

Have your child ever been terminated from a job (Please explain):_____
At any time on the job was your child ever exposed to dangerous chemicals or substances (e.g., Mercury, Lead, Radiation, Solvents, Pesticides, Chemicals, etc.)? ☐Yes ☐No If yes, explain: _____
Have your child ever been injured on the job? ☐Yes ☐No If yes, explain: _____

DOCTOR'S NOTES

Legal History ☐ Not Applicable

Present legal problems (Describe): _____
Past arrests (For what?): _____
Convictions (For what?): _____
Time served in juvenile hall, jail or prison (Give dates and locations): _____

DOCTOR'S NOTES