



AHB Center

FOR BEHAVIORAL HEALTH AND WELLNESS

An Integrative, Compassionate, Personalized Approach

Child/Adolescent History Form

Please complete this confidential form to help us better understand you and your child's concerns.

Child's Name: _____ Age: _____

Date of Birth: _____ Gender: M F

Current Grade: _____ Current School: _____

Family Information

Parents' marital status (check all):

- single, never married
- married
- separated; when: _____
- divorced; when: _____
- widowed; when: _____
- remarried; when: _____

Parent's full name: _____
 Parent's age/occupation: _____
 Parent's full name: _____
 Parent's age/occupation: _____
 Guardian's full name: _____
 Guardian's age/occupation: _____

Please check any of the following that are true for this child:

- was adopted If so, is child aware yes no Age at adoption: _____
- is a foster child If so, since when _____

Who lives in home with child? (mother, father, stepparent, parent's significant other, brothers and sisters, aunts, uncles, grandparents, foster parents, etc.)

Name	Age	Relation to child

If parents are divorced, who has physical custody of this child? _____
 Who has legal custody of this child? _____

Pregnancy History

Please check any of the following, which occurred during the mother's pregnancy with this child.

- | | |
|---|--|
| <input type="checkbox"/> did not receive prenatal care | <input type="checkbox"/> smoking cigarettes |
| <input type="checkbox"/> gestational diabetes | <input type="checkbox"/> alcohol use |
| <input type="checkbox"/> hypertension/high blood pressure | <input type="checkbox"/> prescription drug use type: _____ |
| <input type="checkbox"/> depression, anxiety | <input type="checkbox"/> other drug use type: _____ |
| <input type="checkbox"/> toxemia | <input type="checkbox"/> physical injury/trauma |
| <input type="checkbox"/> anemia (low iron) | <input type="checkbox"/> hospitalization during pregnancy |
| <input type="checkbox"/> RH incompatibility | <input type="checkbox"/> surgery during pregnancy _____ |
| <input type="checkbox"/> infection _____ | <input type="checkbox"/> other _____ |

Child's Birth and Postnatal History

Born: _____ weeks early on-time _____ weeks late
Apgar Scores, if known _____

Birth and delivery:

- | | |
|--|--|
| <input type="checkbox"/> no complications | <input type="checkbox"/> cord around neck |
| <input type="checkbox"/> caesarean section | <input type="checkbox"/> forceps/vacuum assisted |
| <input type="checkbox"/> multiple births | <input type="checkbox"/> other _____ |

How much did baby weigh? _____

How long did baby stay in hospital? _____

Please check any of the following, which applied during the two months after birth:

- | | |
|---|--|
| <input type="checkbox"/> stay in intensive care nursery | <input type="checkbox"/> physical deformities |
| <input type="checkbox"/> breathing problems | <input type="checkbox"/> given medications type: _____ |
| <input type="checkbox"/> jaundice (skin yellow) | <input type="checkbox"/> excessive crying |
| <input type="checkbox"/> cyanosis (skin blue) | <input type="checkbox"/> sleeping problem |
| <input type="checkbox"/> convulsions/seizures | <input type="checkbox"/> very inactive |
| <input type="checkbox"/> feeding problems | <input type="checkbox"/> very jittery |
| <input type="checkbox"/> injury | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> surgery _____ | |

Developmental History

As closely as you can recall, please write the age when your child did the following:

_____ sat up without support	_____ used short sentences
_____ crawled	_____ toilet-trained (day)
_____ walked alone	_____ toilet-trained (night)
_____ gave up bottle/breast	_____ dressed him/herself
_____ spoke first word	_____ drew a circle

Child's Medical History

Please check any of the following that the child has had since birth.

- | | |
|--|---|
| <input type="checkbox"/> Allergies (type: _____) | <input type="checkbox"/> Infections (<input type="checkbox"/> TB, <input type="checkbox"/> CMV, <input type="checkbox"/> HIV) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lead exposure/poisoning |
| <input type="checkbox"/> Bowel problems: _____ | <input type="checkbox"/> Meningitis &/or encephalitis |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Recurrent ear infections/tubes |
| <input type="checkbox"/> Diabetes (<input type="checkbox"/> Type 1 <input type="checkbox"/> Type II) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Eye and/or vision problems | <input type="checkbox"/> Serious injury: _____ |
| <input type="checkbox"/> Endocrine problems _____ | <input type="checkbox"/> Slow weight gain |
| <input type="checkbox"/> Genetic disorder _____ | <input type="checkbox"/> Surgery: _____ |
| <input type="checkbox"/> Head injuries &/or concussions | <input type="checkbox"/> Testing: <input type="checkbox"/> EEG, <input type="checkbox"/> MRI, or <input type="checkbox"/> CT <input type="checkbox"/> |
| <input type="checkbox"/> Headaches &/or migraines | <input type="checkbox"/> Thyroid problems <input type="checkbox"/> hypo <input type="checkbox"/> hyper |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Hospitalization: _____ |
| <input type="checkbox"/> Illness: <input type="checkbox"/> Chicken pox, <input type="checkbox"/> whooping cough, <input type="checkbox"/> measles, <input type="checkbox"/> mumps <input type="checkbox"/> scarlet fever | |

What medication(s) has your child taken or is now taking?

Medication	Dates	Reason	Effectiveness

Daycare/School Information

Please fill in the following information, including daycare:

School	Dates (or ages) attended

Has your child ever repeated a grade, been retained, or held back? yes no
 If so, what grade(s)? _____

Your child's current academic performance:

- Above grade level On grade level Below grade level Inconsistent

Please check any of the following services that your child has ever received.

- | | |
|--|--|
| <input type="checkbox"/> IEP <input type="checkbox"/> 504 Plan since: _____ | Area : _____ |
| <input type="checkbox"/> AIG: <input type="checkbox"/> Reading <input type="checkbox"/> Math | <input type="checkbox"/> occupational therapy (OT) |
| <input type="checkbox"/> self-contained classroom at school | <input type="checkbox"/> physical therapy (PT) |
| <input type="checkbox"/> speech/language therapy (SP/L) | <input type="checkbox"/> other: _____ |

Prior Counseling/Treatment Information

Please list any prior diagnoses:

Diagnosis	Dates (or ages)

Please fill in the following information, regarding past mental health services:

Therapy/Hospitalizations/Community Support/Groups	Dates (or ages)

Behavioral Patterns

Please check and/or circle any of the following that has **ever** been true of your child:

- | | |
|---|---|
| <input type="checkbox"/> Extremely restless/hyperactive | <input type="checkbox"/> Rocking of body |
| <input type="checkbox"/> Clingy/wants to be held too often | <input type="checkbox"/> Aggressive towards others |
| <input type="checkbox"/> Extreme reaction to tastes/being touched | <input type="checkbox"/> Damages property |
| <input type="checkbox"/> Difficulty being consoled/calmed | <input type="checkbox"/> Trouble making eye-contact |
| <input type="checkbox"/> Extreme reaction to noises | <input type="checkbox"/> Is not affectionate |
| <input type="checkbox"/> Seems too sad | <input type="checkbox"/> Making odd sounds, noises |
| <input type="checkbox"/> Seems too happy | <input type="checkbox"/> Seems like they hear voices/see things |
| <input type="checkbox"/> Seems like a "worry-wart" | <input type="checkbox"/> Does not play with other children |
| <input type="checkbox"/> Very irritable/moody | <input type="checkbox"/> Does not seem to pay attention |
| <input type="checkbox"/> Frequent/unpredictable angry outbursts | <input type="checkbox"/> Sexualized language or behavior |
| <input type="checkbox"/> Head banging | <input type="checkbox"/> Talks about suicide/wanting to hurt self |
| <input type="checkbox"/> Cutting/self-harm | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Bedwetting/toileting accidents after 5 | <input type="checkbox"/> Does not seem to pay attention |
| <input type="checkbox"/> Sleep difficulties | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Other: _____ |

Has your child ever been exposed to trauma or violence? yes no

If so, explain: _____

Approximately how many hours per day does your child watch TV or play video games? _____

Approximately how many hours per day does your child spend completing homework? _____

Approximately what time does your child go to bed at night? _____ Awake? _____

Describe special areas of interest or hobbies (e.g., art, reading, sports, church activities, scouts, etc.).

<u>Activity</u>	<u>How much time per week?</u>	<u>How long participated?</u>

Please check any of the following events that have happened for anyone in the family in the past 6 months.

- | | |
|--|--|
| <input type="checkbox"/> increase in marital/relationship conflict | <input type="checkbox"/> trauma or injury |
| <input type="checkbox"/> separation or divorce | <input type="checkbox"/> serious illness/hospitalization |
| <input type="checkbox"/> remarriage | <input type="checkbox"/> new baby |
| <input type="checkbox"/> death in family | <input type="checkbox"/> jail sentence/legal trouble |
| <input type="checkbox"/> substance abuse | <input type="checkbox"/> financial stress |
| <input type="checkbox"/> loss of job/job stress | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> change in living situation | <input type="checkbox"/> other _____ |

Family Background

Indicate if any of the child’s relatives have had any of the following conditions, and write that person’s relationship to the child next to it. By relatives, we mean parents, brothers, sisters, grandparents, aunts, uncles, and cousins on both sides.

<u>Condition</u>	<u>Relationship to child</u>
<input type="checkbox"/> convulsions, seizures, epilepsy	_____
<input type="checkbox"/> speech problems	_____
<input type="checkbox"/> learning problems in reading, writing, math	_____
<input type="checkbox"/> retained/held back in school	_____
<input type="checkbox"/> autism/Aspergers	_____
<input type="checkbox"/> mental retardation	_____
<input type="checkbox"/> hyperactive as a child or (ADD/ADHD) Attention-Deficit/Hyperactivity Disorder	_____
<input type="checkbox"/> depression	_____
<input type="checkbox"/> anxiety	_____
<input type="checkbox"/> Bipolar (manic-depression)	_____
<input type="checkbox"/> eating disorder	_____
<input type="checkbox"/> other mental illness _____	_____
<input type="checkbox"/> suicide attempts	_____
<input type="checkbox"/> alcohol or substance abuse/addiction	_____
<input type="checkbox"/> thyroid disease (hyperthyroidism/hypothyroidism)	_____
<input type="checkbox"/> Other _____	_____

Thank you. We look forward to working with you and your family.