Patient Name: _____ DOB: _____

Child Patient History Form

Please complete the following and attach additional sheets if needed:

Allergies: _____

Current and previous medical history:

_____

_____

_____

_____

Surgical procedures and dates:

_____

Mental health hospitalizations (include year and reason):

_____

Family psychiatric history (list any family member with mental health issues- depression, anxiety, etc.):

_____

Family history of attempted/completed suicide, relation to patient and date/s:

_____

SOCIAL HISTORY

Childhood family dynamics:

Who has custody: _____

Child is in household with who: _____

How are the members of each household related to the child**:** _____

History of Trauma/Abuse

Has patient ever been in a situation where they feared for their life? Yes No

If yes, explain: _____

History of physical abuse: Yes No *Explain:* _____

History of sexual abuse: Yes No *Explain:* _____

History of emotional abuse: Yes No *Explain:* _____

Has the child been in a serious accident? _____

Has the patient ever witnessed the death or abuse of another person? Yes No *Explain:*

_____

Patient Name: _____ DOB: _____

Developmental

Explain any complications during mother's pregnancy:_____

Did mother or father use alcohol, drugs, or tobacco during pregnancy? Yes No

Explain:_____

Did mother use prescription drugs during pregnancy*?* Yes No *Explain:* _____

Did the parents live together during the pregnancy: Yes No

How old were the parents when the child was born: _____

Labor complications: _____

Birth weight: _____ **Premature birth?** _____

Delays in development (ex. crawling, walking, sentences, social interactions): _____

School History

Current grade in school: _____**Current grades in school:** _____

Any repeated or failed grades: _____

Conduct issues: _____

Special needs "504/IEP": _____

Describe the child's peer relationships: _____

Friends/Peer Groups

Does the patient have a boyfriend/girlfriend? _____ **Relationship is described as:**

_____

Is the patient sexually active? _____ **History of pregnancy:** _____

History of STD: _____

Tobacco/Drugs/Substance Use

Tobacco use: _____ **Vape use:** _____

Alcohol use: _____ **Marijuana use:** _____

Street drug use: _____ **Alcohol use:** _____

Prescription drug use: _____

Extracurricular Activities

Is the patient involved in extracurricular activities: Yes No *Explain:* _____

Adolescent Work History

Adolescent work history: Not employed Part time Full time *Where:* _____

Patient Name: _____ DOB: _____

Legal

Legal and arrest history (if applicable):

_____

_____

Does the patient have a JPO: _____

Court or drug referral/treatment: _____

Suspended/expelled from school: _____

Is patient currently in state custody: _____

Past mental health treatment/counseling: currently past previous IOP drug court

mandated mental health treatment drug counseling school counselor intervention

**If any of the above are circled, please explain:*

_____

_____