ADOLESCENT HEALTH HISTORY

TO BE COMPLETED BY A PARENT OR GUARDIAN

The information you provide will be very helpful in effectively treating your child. Please fill out the form completely and attach extra pages if needed. Your child's clinician will review the form with you. Thank you!

Today's Date: _____ Child's Name: _____

Date of birth: _____ Age: _____ Gender: _____ Grade: _____ Cell phone: _____

Parent/Guardian 1

Name: _____ Gender ■M ☐F

Street Address: _____ Legal guardian? ☐Y ☐N

City/State/Zip: _____ Lives with child? ☐Y ☐N

Home Phone: _____ Biological parent? ☐Y ☐N

Work Phone: _____

Cell Phone: _____

Name of spouse/partner: _____

Parent/Guardian 2

Name: _____ Gender ☐M ☐F

Street Address: _____ Legal guardian? ☐Y ☐N

City/State/Zip: _____ Lives with child? ☐Y ☐N

Home Phone: _____ Biological parent? ☐Y ☐N

Work Phone: _____

Cell Phone: _____

Name of spouse/partner: _____

Health Insurance Information

Name of primary insured family member: _____ Date of birth:_____

Name of insurance carrier: _____

Policy #: _____

Group # (if applicable): _____

Who referred you? (e.g., hospital, therapist, insurance company, etc.)

_____

Please explain the reason for your visit today (e.g., main problems/concerns):

For how long have these problems been occurring? _____

Why do you think your child is having difficulty?

What would you, your child, and/or the referring individual like to see done for your child?

What psychiatric diagnoses (if any) does your child have?

DIAGNOSIS	DATE ESTABLISHED	BY WHOM?

Current Medications

List all psychiatric, non-psychiatric (prescription), and over-the-counter medications.

NAME	DOSE	FREQUENCY	DATE STARTED	PRESCRIBED BY

Is your child taking all medications as prescribed? ☐YES ☐NO

If no, please explain:

_____

Drug Allergies:

_____

Previous Psychiatric Medications

NAME	DOSE/FREQUENCY	DATES OF TREATMENT	REASON STOPPED

PSYCHIATRIC HISTORY

Has your child been hospitalized for psychiatric reasons? ☐YES ☐NO

If yes: Total # of hospitalizations: _____

Age at first hospitalization: _____

Please list the 5 most current hospitalizations, beginning with the most recent.

DATES (FROM-TO)	FACILITY	REASON

Has your child been to a **detox/drug rehab** program? ☐YES ☐NO

If yes: Age when started treatment: _____

Facility: _____

Reason for treatment: _____

Has your child received **psychiatric medication evaluations** before? ☐YES ☐NO

If yes: Age when started treatment: _____

Reason for treatment: _____

NAME/LOCATION OF PSYCHIATRIST OR NP	DATES OF TREATMENT

Has your child received **counseling/psychotherapy** before? ☐YES ☐NO

If yes:

Age when started treatment: _____

Reason for treatment: _____

NAME/LOCATION OF THERAPIST	DATES OF TREATMENT

Has your child had any frightening or traumatic experiences? If yes, please describe.

Accident: ☐NO ☐YES _____

Medical trauma: ☐NO ☐YES _____

Significant loss: ☐NO ☐YES_____

Physical abuse: ☐NO ☐YES _____

Sexual abuse: ☐NO ☐YES _____

Neglect: ☐NO ☐YES_____

Witness to violence: ☐NO ☐YES_____

Bullying: ☐NO ☐YES _____

Other: ☐NO ☐YES _____

MEDICAL HISTORY

Name/location of child's primary care provider (PCP): _____

_____

Date child last saw PCP: _____ Reason: _____

Date of last physical exam: _____ Outcome: NORMAL __ CONCERNS (Explain:)

Child's current height: _____ Weight: _____

Is your child sexually active? ☐YES ☐NO ☐UNKNOWN

Date of last menstrual period (if applicable): _____

Please review the following list and check all health problem(s) that apply to your child, and then provide a brief explanation below:

- ☐ 1. Loss of consciousness or head injury
- ☐ 2. Seizures or convulsions
- ☐ 3. Diabetes
- ☐ 4. Insomnia
- ☐ 5. Chronic fatigue
- ☐ 6. Anemia or blood count abnormalities
- ☐ 7. Thyroid problems
- ☐ 8. Weight gain/loss
- ☐ 9. Nausea; stomach pain; gastric/bowel problems
- ☐ 10. Kidney or urinary problems
- ☐ 11. Heart problems
- ☐ 12. Asthma
- ☐ 13. Allergies
- ☐ 14. Rashes/skin problems
- ☐ 15. Trouble with vision
- ☐ 16. Trouble with hearing
- ☐ 17. Serious injury
- ☐ 18. Poisoning or overdose
- ☐ 19. Gynecological issues
- ☐ 20. Other

#____ Explain: _____

#____ Explain: _____

#____ Explain: _____

#____ Explain: _____

#____ Explain: _____

Has your child been hospitalized for medical reasons, including surgery? ☐YES ☐NO

If yes:

DATES (FROM-TO)	FACILITY	REASON

DEVELOPMENTAL HISTORY

Pregnancy

Parental relationship at the time of pregnancy: _____

Relationship to pregnancy:

Planned
Unplanned
Wanted child
Did not want child

Prenatal care? NO YES (started when): _____

Complications during pregnancy? ☐NO ☐YES _____

Medications taken during pregnancy? ☐NO ☐YES _____

Alcohol/substance use during pregnancy? ☐NO ☐YES _____

Months total gestation: _____

Birth

Age of mother at time of delivery: _____

Labor difficulties (check all that apply):

☐ Prolonged labor ☐ Loss of oxygen
☐ Breach birth ☐ Other:
☐ Cesarean section

Weight: _____ lbs _____ oz Length: _____ inches

Postnatal

Medical complications (check all that apply):

☐ Jaundice ☐ Heart problems
☐ Respiratory problems ☐ Infection
☐ Need for incubation ☐ Other: _____

Postpartum depression for mother? ☐YES ☐NO

If yes, did the child's mother receive the following treatment?

Therapy: NO YES (How long?) _____

Medication: NO YES (Name/dose/duration of treatment): _____

Milestones

At what age did your child do the following?

Sat unsupported: _____ months
Crawled: _____ months
Walked: _____ months
Spoke single words: _____ months
Spoke two word phrases: _____ months
Fully toilet trained: _____ months

Did you child receive early intervention services? ☐NO ☐YES

If yes, Reason: _____

Duration of intervention (age started – age completed): _____

Outcome: _____

Please describe the child as an infant/toddler (e.g., cheerful, fussy, cuddly, withdrawn):

_____

SOCIAL HISTORY

Education/School

CURRENT SCHOOL: _____ Grade: _____

Has the child repeated any grades at school? ☐NO ☐YES

If yes, grade repeated and reason:_____

Suspensions/Expulsions: ☐NO ☐YES (please describe): _____

Transfers: ☐NO ☐YES (please describe): _____

Is the child enrolled in special education classes? ☐NO ☐YES Since what grade? _____

Does the child have an IEP? ☐NO ☐YES

If yes, is the IEP for: ☐ Learning ☐ Behavior ☐ Learning and Behavior

Does the child have a 504 Plan? ☐NO ☐YES (Describe): _____

Does the child receive services from the school adjustment/guidance counselor?
☐NO ☐YES (Please describe): _____

Please describe the child's effort/attitude toward school and academic performance:

Does the child have a job? ☐NO ☐YES
If yes:
Place of employment: _____ Occupation: _____
Length of employment: _____ # of hours worked weekly: _____

Please list some of the child's interests, talents, and favorite activities:

LEGAL HISTORY

Which of the following (if any) applies to your child/family? Please explain the date intervention occurred and for what reason:

Arrests _____
CHINS (Children in Need of Services) _____
Probation _____
Restraining order _____
Victim/Witness _____
DCYF (Division for Children Youth & Families) Services _____
_____

CHILD'S SUBSTANCE USE

DRUG	AGE FIRST USED	ROUTE OF ADMINISTRATION (e.g., swallow, smoke, snort, inject, etc.)	CURRENT AVERAGE USE (In the past 30 days) List amount/frequency
Cigarettes			
Alcohol			
Marijuana			
Cocaine/Crack			
Heroin			
MDMA (Ecstasy/Molly)			
Prescription medication 1. Opioid pain killers (e.g., OxyContin, Vicodin) 2. Benzodiazepines (e.g., Klonopin, Xanax) 3. Stimulants (e.g., Adderall, Ritalin) 4. Other: _____	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.
LSD/Acid			
Glue, Aerosols, Poppers, other inhalants			
DXM/CCCs (cough medicines)			
Other:			

FAMILY

	NAME	AGE	LIVES IN CHILD'S MAIN HOUSEHOLD?
Mother	☐Biological ☐Adoptive		☐YES ☐NO Highest education level attained:
Father	☐Biological ☐Adoptive		☐YES ☐NO Highest education level attained:
Step-Mother			☐YES ☐NO
Step-Father			☐YES ☐NO
Brother(s) Please designate: **(SB)** if step-brother **(HB)** if half-brother	1. 2. 3. 4. 5.		1. ☐YES ☐NO 2. ☐YES ☐NO 3. ☐YES ☐NO 4. ☐YES ☐NO 5. ☐YES ☐NO
Sister(s) Please designate: **(SS)** if step-sister **(HS)** if half-sister	1. 2. 3. 4. 5.		1. ☐YES ☐NO 2. ☐YES ☐NO 3. ☐YES ☐NO 4. ☐YES ☐NO 5. ☐YES ☐NO

In addition to family members listed above, does anyone else reside in the child's main household?
☐NO ☐YES If yes, please provide name, age and relationship to child:

Child was raised by: _____
To whom is the child primarily attached? _____

Has the child experienced a change in caretakers or parental separation? ☐NO ☐YES
Please describe:

_____

How would you describe the child's home environment? (e.g., structured, chaotic, supportive, strict, tense, easygoing)

Describe any **BEHAVIOR** of yourself, partner, or other adults in the home that may have affected your child (e.g., verbal/physical conflict, drinking/drugs, suicide attempts, etc.):

Describe any **EVENTS** that may have affected your child (e.g., family illness, death, separation, divorce, relocation, change in family finances, etc.):

Ethnic/Cultural background of child: _____

Religious/Spiritual background of child: _____

Family Psychiatric Illnesses (Please check where applicable for known/suspected family diagnoses)

ILLNESS	Biological Mother	Biological Mother's Family	Biological Father	Biological Father's Family	Biological Siblings	Other Biological Relative
Depression	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐
OCD	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐
Learning Disorder	☐	☐	☐	☐	☐	☐
Asperger Syndrome/Autism	☐	☐	☐	☐	☐	☐
Alcohol Dependence	☐	☐	☐	☐	☐	☐
Drug Dependence	☐	☐	☐	☐	☐	☐

_____ _____

Parent/Guardian Signature Date

_____ _____

PMHNP Signature Date