

Child Mental Health History

Name: _____

Date: _____

What are the goals for your child's treatment? What changes would you like to see?
Is your child bothered by problems with sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:
Is your child bothered by hearing or seeing things, or by voices? <input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:
Does your child have difficulty with focusing on tasks or finishing things? <input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:

Psychiatric History:		
Is your child currently receiving any type of psychotherapy or counseling?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, by whom?	Phone:	
Does your child have a history of mental health problems or hospitalizations?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If so please complete the following:		
Diagnosis	Dates Treated	By Whom

Most parents have thoughts or opinions about the use of psychiatric medications used to treat children. Please explain your views on mental health medications for your child:

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Medications taken previously (if any):			<input type="checkbox"/> My child has never taken medication
Prozac (fluoxetine)	Lamictal (lamotrigine)	Buspar (buspirone)	
Zoloft (sertraline)	Topomax	Adderall (amphetamine)	
Luvox (fluvoxamine)	Seroquel (quetiapine)	Concerta (methylphenidate)	
Paxil (paroxetine)	Risperdal (risperidone)	Ritalin (methylphenidate)	
Celexa (citalopram)	Zyprexa (olanzapine)	Strattera (atomoxetine)	
Lexapro (escitalopram)	Geodon (ziprasidone)	Vyvanse (lisdexamphetamine)	
Effexor (venlafexine)	Abilify (aripiprazole)	Focalin (dexmethylphenidate)	
Pristiq (desvenlafexine)	Tenex (guanfacine)	Daytrana patch (methylphenidate patch)	
Cymbalta (duloxetine)	Vistaril (hydroxyzine)	Intuniv (guanfacine ER)	
Wellbutrin (bupropion)	Xanax (alprazolam)	Clonidine	
Desyrel (trazodone)	Ativan (lorazepam)	Neurontin (gabapentin)	
Remeron (mirtazapine)	Restoril (temazepam)	Emsam (selegiline patch)	
Tegretol (carbamazepine)	Klonopin (clonazepam)	Other medications:	
Lithium	Valium (diazepam)		
Depakote (valproate)	Ambien (zolpidem)		

Medical Information			
Allergies:			
Current prescription medications:			
Medication	Dosage	Frequency	Prescribed by

Current over the counter medications, herbal remedies, and nutritional supplements:

Current medical problems:

Past medical problems, hospitalizations, and surgeries:

Do you have any other concerns about your child's health that you'd like to discuss with me during our appointment?		() Yes () No
Primary care provider:		
Date and place of last physical exam:		
Has your child ever had an EKG (heart)?	() No () Yes/Date: _____	If yes, please describe:

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Medical Information (continued)	
An MRI/PET/CT brain scan? <input type="checkbox"/> No <input type="checkbox"/> Yes/Date: _____	If yes, please describe:
An EEG (monitor for seizures)? <input type="checkbox"/> No <input type="checkbox"/> Yes/Date: _____	If yes, please describe:

Check if your child has a history of:		
Anemia	Anxiety	Asthma
Attention problems	Bipolar	Cancer
Depression	Dental problems	Diabetes
Digestive problems	Ear infections	Feeding problems
Heart problems	Head trauma	Panic attacks
Psychosis	Seizures	Strep infections
Speech problems	Stomach problems	Other:

Family History:
If your child has biological relatives who have experienced the above or other health problems, please describe:

Please list all biological relatives who have been diagnosed with the following conditions:			
Depression		Anxiety	
Anger		Violence	
ADHD/ADD		Alcohol abuse	
Eating disorder		Drug abuse	
Bipolar (manic depressive)		Schizophrenia	
To your knowledge, has any family member attempted suicide?		<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, whom?
Has any family member been treated with a psychiatric medication? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what medications, and how effective were they?			

Substance Use:	
Has your child ever been treated for alcohol or drug use or abuse?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, for which substances?
If yes, where were they treated and when?	
To your knowledge, has your child ever tried alcohol or other drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes	

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Legal History:
Has your child ever been arrested? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain:
Does your child have any pending legal problems? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain:

Developmental History:
Was your child adopted? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, at what age?
When your child was born were there any medical concerns during labor, delivery or immediately after his/her birth? If yes please describe: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure
Developmental milestones (sitting up, walking, talking, toilet training, etc.) were: <input type="checkbox"/> On time <input type="checkbox"/> Delayed <input type="checkbox"/> Earlier than other children <input type="checkbox"/> Not sure
How many brothers or sisters? How old are they?
Mothers occupation: _____ Fathers occupation: _____
Has your child experienced parental divorce? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how old was your child?
If so, with whom does your child live?
Describe your child's relationship with you:
Describe your child's relationship with their other parent(s):
What, if any, are your child's responsibilities at home?

Trauma History
To you knowledge, was your child ever physically, verbally, or sexually abused? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, please describe:
Has your child ever experienced the loss or death of a close loved one? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please briefly describe circumstances:

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Spirituality	
Does your family belong to a particular religion or spiritual group? If yes, what is the level of your family's involvement?	() No () Yes
If your family does not belong to a group, does your family have any spiritual beliefs or life philosophy that is particularly important to you? Please explain:	() No () Yes

Educational History:	
What school does your child attend?	
How are his/her grades?	
Does your child have any identified learning disabilities?	
If your child has had any specialized academic testing, please describe:	
How does your child do socially at school?	
What are your child's best subjects?	
Worst subjects?	
What do your child's teachers say about him/her?	

Recreation:			
What kind(s) of exercise does your child get?			
In what after school activities does your child participate?			
Does your child play video games?	() No () Yes If yes, how many hours per day?	Per week?	
Does your child watch television?	() No () Yes If yes, how many hours per day?	Per week?	
Does your child have television or computer in their bedroom?	() No () Yes		
Does your child have their own cell phone?	() No () Yes		
How often does your child visit with his or her friends?			
What do you think about your child's group of friends?			
What are your child's personal strengths?			

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Other Concerns

What are your child's personal strengths?

Please describe any concerns about your cost of treatment (copay, medication costs, etc.)

Your child's comfort is very important, and some material is better discussed with them not present. Is there anything in the above information that you do not want your child to know?

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