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ADULT, CHILD AND ADOLESCENT PSYCHIATRY

CHILD-ADOLESCENT FAMILY INFORMATION

Patient's Name:_____Age:_____

Date of Birth:_____Social Security Number_____

Address:_____

Parents are: Married, Divorced, Separated, Never Married, Widowed

Custodial Parent or Guardian (if applies):_____

Home Phone:_____ Cell Phone:_____

Referred by:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____

Family Physician / Pediatrician:_____

Address:_____

City:_____State:_____Zip:_____

Telephone:_____

Signature of Person completing Form:_____

Relationship to Patient:_____Date:_____

Insurance _____

Policy Holder_____ Policy Number_____

Group number_____

Insurance Billing info/address_____

_____

PARENT OR GUARDIAN INFORMATION

Indicate home address & phone only if different than patients

MOTHER

Name:_____

Address:_____

_____

Phone:_____Cell Phone:_____

Employer:_____

Address:_____

Job Title:_____

Work Phone:_____Work Hours:_____

FATHER

Name:_____

Address:_____

_____

Phone:_____Cell Phone:_____

Employer:_____

Address:_____

Job Title:_____

Work Phone:_____Work Hours:_____

GUARDIAN / OTHER

Name:_____

Relation to Patient:_____

Employer:_____

Address:_____

Job Title:_____

Work Phone:_____Work Hours:_____

SCHOOL INFORMATION

Name of School:_____Grade:_____School District:_____

Grades repeated:_____Number of School Changes (Districts)_____

Special Services: (Circle any that apply): Individual Testing Speech/Language

SBH LD DH Home School Other:_____

PAST OF CURRENT MENTAL HEALTH SERVICES

Services Provided: (Circle all that apply):

Family Therapy Individual Therapy Group Therapy

Medication Day Treatment Hospitalization

Residential Treatment Other:_____

Services Provided at age (s):_____

Services Provided by:_____

_____

_____

_____

CHILDREN'S SERVICES

Contact with Children's Services (Circle One) Yes No

If Yes, When:_____

County:_____

Caseworker:_____

COURT AND/OR POLICE CONTACTS

Contact with Court or Police? (Circle one) Yes No

If Yes, When:_____County:_____

Charges:_____

Probation Officer:_____

PEOPLE NOW LIVING IN PATIENT'S HOME

Name	Relationship to Patient	Age	Sex	Grade in School or Years of Education & Occupation

FAMILY MEMBERS LIVING AWAY FROM PATIENT'S HOME

Name	Relation to Patient	Age	Sex	Grade in School or years of Education & Occupation

COMMUNITY SUPPORTS, RESOURCES

What community resources does child need or use? (e.g. clubs, Church, etc.)

Who can child count on to help or be a support?

Are there any cultural factors which might affect child and treatment?

Please answer the following questions about your child or adolescent:

What are your child's most serious problems?

When were you first aware of these problems?

What have you tried to solve these problems?

What has helped?

Check any **changes or stresses** that might have brought on or added to these problems:

	X		X
New brother / sister		Family financial pressures	
Traumatic experience (accident, abuse, etc.)		Job changes	
School pressures		Moves	
School change		Divorce / separation	
Activity / sports pressures		Marriage / new relationship	
Loss / change of friends		Family medical illness	
Alcohol use		Deaths.	
Drug use		Legal problems	
Health problems		Legal problems	
Witnessing abuse or violence		Other	

What are your child's strengths, talents, or "positives"?

What are your family's important supports? (e.g., Church, friends, etc.)

DEVELOPMENTAL INFORMATION

Either circle the appropriate answer or fill in the blank			EXPLAIN ANY PROBLEMS
ADOPTION, GUARDIANSHIP, FOSTER			
Circle one if child is: foster adopted under guardianship other			
Age when child came under your care_____			
PREGNANCY			
Was pregnancy unexpected?	Yes	No	
Did mother receive prenatal care during pregnancy?	Yes	No	
Mother's age at delivery?_____			
Were there any problems with pregnancy?	Yes	No	
Were medicines taken (other than vitamins and iron?)	Yes	No	
Did mother drink and/or use drugs during pregnancy?	Yes	No	
Were there serious emotional stresses or family problems during pregnancy?	Yes	No	
Was child born more than 3 weeks before or after expected date?	Yes	No	
Were there any problems with delivery?	Yes	No	
Was birth by "C" Section?	Yes	No	
Were there any problems with child noticed at birth?	Yes	No	
Birth Weight?_____			
Place of Birth?_____			
Did child remain in the hospital after mother had left?	Yes	No	
00 – 12 MONTHS			
During first year was child:			
Easy Average Difficult			
Unusually fuzzy, very hard to soothe?	Yes	No	
Unusually quiet, not responding much to attention?	Yes	No	
Hard to cuddle (stiff or floppy)?	Yes	No	
Not interested in looking at people?	Yes	No	
Having many feeding problems?	Yes	No	
Slow to smile?	Yes	No	
Slow to sit or crawl?	Yes	No	
Other unusual behaviors?	Yes	No	

			EXPLAIN ANY PROBLEMS
1 – 5 YEARS			
During these years your child is/was			
Easy Average Difficult			
Late walking?	Yes	No	
Late talking?	Yes	No	
Hard to understand?	Yes	No	
Awkward or clumsy?	Yes	No	
Said to be slow, delayed, or retarded?	Yes	No	
Difficult to toilet train?	Yes	No	
Unusually active or hyperactive?	Yes	No	
Hard to control in public places?	Yes	No	
Hard for anyone outside the immediate family (baby-sitter) willing or able to manage child's behavior?	Yes	No	
Impulsive? (Acting without appropriate fear or caution- e.g. running out into traffic?	Yes	No	
Unusually upset by changes or new situations;insisting everything remain the same?	Yes	No	
Bothered by unusual fears?	Yes	No	
Showing unusual behaviors, body movements, tics, or nervous habits?	Yes	No	
Very destructive of property or toys?	Yes	No	
Having sever or frequent temper tantrums?	Yes	No	
Setting fires?	Yes	No	
Very demanding, wanting things right away?	Yes	No	
Having trouble sharing or taking turns?	Yes	No	
Having frequent sleep problems?	Yes	No	
Often very upset, (explosive) over little frustrations?	Yes	No	
Unable to play well with other children?	Yes	No	
Uninterested in playing with other children?	Yes	No	
Unable to get along well in pre-school or Kindergarten?	Yes	No	
Having trouble with changes in the family (new baby, moves, etc.)?	Yes	No	
Very upset and/or resistant to being away from parents?	Yes	No	
Having frequent difficulties with eating?	Yes	No	
Having any other difficulties?	Yes	No	

6 – 12 YEARS			Explain any problems
***During these years your child has/had had**:*			
Trouble getting along with family members?	Yes	No	
Trouble being away from home or parents?	Yes	No	
Trouble making or keeping friends?	Yes	No	
No interest in being with other children?	Yes	No	
Problems in school with (circle all that apply): learning behavior attendance	Yes	No	
Behavior problems (circle all that apply): destructive lying stealing explosive cruel to people/animals fighting threatens to kill	Yes	No	
Mood problems (circle all that apply): depressed suicide threats suicide attempts very shy very nervous panic attacks	Yes	No	
Sleep problems?	Yes	No	
Many physical problems or complaints?	Yes	No	
Unusual body movements or tics?	Yes	No	
Eating problems or concerns?	Yes	No	
Other problems or behavior difficulties?	Yes	No	
12 – 18 YEARS			
During these years your adolescent has/ has had:			
Trouble getting along with family members?	Yes	No	
Trouble being away from home or family?	Yes	No	
No interest in being with other adolescents?	Yes	No	
Trouble making or keeping friends?	Yes	No	
Interest only in friends with serious problems?	Yes	No	
Problems at school with (circle all that apply): achievement behavior attendance	Yes	No	
Behavior problems (circle all that apply): drug use Alcohol use destructive explosive Cruel to people or animals threatens to kill Fighting lying stealing other	Yes	No	
Mood problems (circle all that apply): shy nervous Panic attacks depressed suicide threats/attempts	Yes	No	
Sleep problems?	Yes	No	
Eating problems or concerns?	Yes	No	
Many physical problems or complaints?	Yes	No	
Other problems or behavior difficulties?	Yes	No	

CHILD AND ADOLESCENT MEDICAL HISTORY

1. Circle Immunizations Received:

Age			
0 -04 Years	DPT	Polio	Measles/Mumps/Rubella
5 Years	DPT	Polio	
14 – 16 Years	Tetanus	Polio	Measles/Mumps/Rubella
	Other		

2. Date of last physical Examination:_____

3. Hospitalizations, serious illnesses, injury or surgery:

Age	Hospital	Illness/Surgery/Injury

4. Serious or chronic health problems:

Age of Diagnosis	Problem

5. Allergies to medications:_____

6. Other allergies:_____

7. Medication now being taken:

Medication	Reason

8. Medications ever taken for behavior or emotional problems:

Age	Medication	Response

Check if your child has had problems with:

	Problem	Describe Problems Checked
	Vision/Eyes	
	Hearing/Ears	
	Heart/Heart Murmur	
	Lungs/Asthma	
	Stomach Pain/Ulcer/Vomiting/Constipation/ Diarrhea	
	Joint Pain/Swelling	
	Kidneys/Urination/Bladder or Kidney Infections/Bedwettting	
	Seizures/Fainting/Blackouts	
	Appetite/Large Weight Gain or Loss	
	Sexually Transmittted Disease(s)	
	Uses Tobacco (Smokes/Chews)	
	Uses Alcohol or Drugs	
	Sexually Abused or Raped	
	Physically Abused	
	Exposure to toxic substances	
	Other	

10. Has your child entered puberty (begun to have sexual development)?

    If yes, age_____

11. Is your child sexually active?_____

12. For girls: (Check, circle, and complete, if applies):

    Age at 1st menstrual Period:_____

    Pain/Difficulty with Periods:_____

    Pregnancy/Miscarriage/Abortion:_____

    For boys: (Check and circle, if applies):

    Impregnated a girl or fathered a child? Yes No

FAMILY MEDICAL HISTORY

Check the item if there is any family member with the problem (parents, sisters, brothers, cousins, aunts, uncles, grandparents, etc.

Illness	X	Relation to child
AIDS		
Cancer		
Diabetes		
Heart disease		
High Blood Pressure		
Kidney Disease		
Multiple Sclerosis		
Seizures		
Sickle Cell Anemia		
Stroke		
Tuberculosis		
Sudden Death		
Sever Injury		
Other		

FAMILY AND HOME SAFETY

Guns in the home		
Dangers in area		
Toxins (Lead, etc.)		
Other		

FAMILY MENTAL HEALTH HISTORY

Check the item if there is any family member with the problem (parents, sisters, brothers, cousins, aunts, uncles, grandparents, etc.

Illness or Problem	X	Relation to child

Alcoholism		
Drug Abuse		
Other Addictive Disorders		
Depression		
Deliberately Harmed Self		
Suicide Attempt		
Suicide		
Attention Problems or ADD"		
Hyperactivity		
Learning Problems or Dyslexia		
Tics or Tourette's Disorder		
Special Classes in School		
Mental Retardation		
Obsessive Compulsive Disorder		
Severe Anxiety, Fears, or Phobias		
Panic Attacks		
Eating disorder (Anorexia, Bulimia)		
Manic Depressive or Bipolar Disorder		
Schizophrenia		
Victim or Physical Abuse		
Victim or Sexual Abuse or Rape		
Post Traumatic Stress disorder		
Violent or Abusive Behavior		
Violent Sexual Behavior, Rape		
Jail Sentence		
Other		

PARENTS' RELATIONSHIPS			
13.MOTHER'S MARRIAGES AND/OR IMPORTANT RELATIONSHIPS			
Spouse or Partner's Name	Year Married or	Year of Separation, Divorce, or Death (Indicate which)	Children of Marriage or

	Begun		Relationship – List Names and Year of Birth

Important problems or events in relationship(s):

FATHER'S MARRIAGES AND/OR IMPORTANT RELATIONSHIPS

Spouse or Partner's Name	Year Married or Begun	Year of Separation, Divorce, or Death (Indicate which)	Children of Marriage or Relationship – List names and Year of Birth

Important problems or events in relationship(s):

14. **MOTHER'S FAMILY** (Child's mother, grandparents, aunts, uncles, etc.)

List mother first, then her mother and father (child's grandparents), then her brothers, sisters (child's aunts, uncles); also list any step parents, and step or half brothers or sisters:

Name	Relationship to mother	Age now if alive	Age at death	Year of death

Did mother have problems with or in her family during childhood or teen years?
Yes No

If yes, describe:

Are there problems with or in family now? Yes No

If yes, describe:

15. **FATHER'S FAMILY** (Child's father, grandparents, aunts, uncles, etc)				
List father first, then his mother and father (child's grandparents), then brothers, sisters: (child's aunts, uncles); also list any step parents, and step or half brothers or sisters:				
Name	Relation to you	Age now if	Age at death	Year of death

		alive		

Did father have problems with or in his family during childhood or teen years?
Yes No

If yes, describe:

Are there problems with or in family now? Yes No

If yes, describe: