CHILD AND ADOLESCENT MEDICAL HISTORY QUESTIONNAIRE

Please complete the following form about your child to the best of your knowledge. These questions are intended to elicit basic background information about your child and your family prior to our first visit. Much of this information will be discussed in greater detail during your appointment. Please leave questions blank if they do not pertain to you or if you do not feel comfortable answering.

Who referred your child? _____

What was their concern? _____

What is your primary concern? _____

What is the school's primary concern? (if applicable) _____

When did you first become aware of these concerns? _____

Name of Child _____
First Middle Last

Street Address _____

City _____ State _____ Zip _____

Phone # _____ Email (best address for office contact) _____

Age _____ Date of Birth _____ Place of Birth _____

Height _____ Weight _____

Preferred Pharmacy (Name and Address) _____

Who has legal custody or guardianship of the child? _____
(*Please be prepared to provide supporting documentation of custody/guardianship/medical decision making at first visit, if applicable*)

FAMILY INFORMATION

FATHER:
Name _____ Date of Birth _____

Address (if different from above) _____

Cell Phone _____ Work Phone _____ Email _____

Place of Employment _____ Title _____

Highest Level of Education _____

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MOTHER:
Name _____ Date of Birth _____

Address (if different from above) _____

Cell Phone _____ Work Phone _____ Email _____

Place of Employment _____ Title _____

Highest Level of Education _____

STEPMOTHER:
Name _____ Date of Birth _____

Address (if different from above) _____

Cell Phone _____ Work Phone _____ Email _____

Place of Employment _____ Title _____

Highest Level of Education _____

STEPFATHER:
Name _____ Date of Birth _____

Address (if different from above) _____

Cell Phone _____ Work Phone _____ Email _____

Place of Employment _____ Title _____

Highest Level of Education _____

Please provide marital history (including dates of all marriages, divorces, and remarriages) for parents and stepparents.

List the names of all siblings, including stepbrothers and sisters, half brothers and sisters, and any miscarriages or stillbirths. Also give a brief description of each child (age, relationship, school status).

NAME	**AGE**	**RELATIONSHIP**	**SCHOOL STATUS AND/OR OCCUPATION**
ex. John	*8 years old*	*Brother*	*2nd grade at Smith Elementary School*

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List other children or adults who have lived or are now living in the home and their relationship to your child.

Does anyone who lives in the home smoke cigarettes? _____

List dates of moves and for what reasons. _____

How long at present address? _____

DEVELOPMENTAL INFORMATION

Length of Pregnancy _____ weeks Birth Weight _____ lb _____ oz

Planned or unplanned pregnancy _____

Was the pregnancy complicated or involved with drugs or alcohol? _____

Nature of delivery: ☐Vaginal ☐Caesarian ☐Breech

Condition of child at time of birth _____

If child was adopted, from where? _____

At what age was child adopted? _____

Age of parent at time of birth or adoption: Father _____ Mother _____

Please give age your child: Walked: _____ Talked: _____ Toilet trained: _____

Has your child ever been exposed to abuse? If comfortable, please state whether it is/was physical, emotional or sexual and whether he/she was the object of the abuse or exposed to it.

Please list any additional stressors or traumas for the family and child

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EDUCATION HISTORY

Current School _____

Grade _____

Teacher(s) _____

Teacher Contact Information (phone and/or email) _____

List, in order of attendance, all school enrollments your child has had. Give name and city/state. Indicate if it was a public or private school and the grade attended.

School	City/State	Public/Private	Grade(s) Attended	Average Grade (A-F)

Have any grades been repeated? _____

Has your child been given a diagnosis of a learning disability? By whom? _____

Has your child been identified for special education, learning support, or emotional support? Please state year identified and describe provisions made. _____

SYMPTOM CHECKLIST

Please check those items that pertain to your child:

- ☐ Often fails to finish things he or she starts
- ☐ Easily distracted
- ☐ Has difficulty concentrating
- ☐ Shifts excessively from one activity to another
- ☐ Frequently is disruptive in class
- ☐ Has difficulty awaiting his/her turn (ex. games)
- ☐ Has difficulty sitting still
- ☐ Impulsive or acts without thinking
- ☐ Abusive to animals
- ☐ Physically violent towards others
- ☐ Physically violent towards property (vandalism, destructive)
- ☐ Firesetting
- ☐ Stealing, Shoplifting, Breaking and Entering
- ☐ Runaway
- ☐ Lying

☐Chronic violation of parental limits
☐Smokes Cigarettes (how many packs per day?) (for how long?)
☐Drug Abuse (what kind?)
☐Alcohol Abuse (what kind?)
☐Any involvement with juvenile court
☐Unrealistic fears (Explain)
☐Acts too young for his/her age
☐Clings to adults or too dependent
☐Irritable
☐Feels no one loves him/her
☐Gets teased a lot
☐Complains of loneliness
☐Demands a lot of attention
☐Easily made jealous
☐Refusal to attend school
☐Avoidance of being left alone
☐Excessive need for reassurance
☐Very self-conscious or easily embarrasses
☐Often appears tense and unable to relax
☐Frequent physical complaints (i.e. headaches, stomach aches, nausea)
☐Overly concerned with future events
☐Nervous mannerisms (i.e. nail biting, thumb sucking, rocking)
☐Feelings of inadequacy
☐Panic – feelings of intense fear/discomfort with palpitations, tremors, shortness of breath, choking feelings, etc.
☐Obsessions – unwanted ideas, images or impulses that intrude on thinking despite efforts to resist them. (Fear of contamination, recurring doubts about danger, extreme concern with order, symmetry or exactness)
☐Can't get his/her mind off certain thoughts
☐Fears he/she may do something bad
☐Thinks she/he has to be perfect
☐Strange thoughts or ideas (Explain)
☐Hallucinations – visual or auditory (Describe)
☐Inappropriate expression of feelings (ex. laughing at something sad)
☐Concern that people are out to get him/her
☐Severe mood changes (ex. very sad to very happy)
☐Deliberately harms self
☐Often appears sad
☐Confused or seems to be in a fog
☐Day dreams or gets lost in his/her thoughts
☐Doesn't seem to have much energy
☐Social withdrawal
☐Overtired
☐Pessimistic outlook toward the future
☐Excessive tearfulness or crying
☐Recurrent thoughts about death or preoccupation with death
☐Suicidal thoughts or verbalized intentions
☐Suicide attempts

☐Poor relationship with parents
☐Sibling rivalry
☐Negative peer associates-hangs with others that get in trouble
☐Argues a lot, bragging, boasting
☐Mean to others

☐Has difficulty making or keeping friends
☐Does not associate with people his or her own age
☐Avoids unfamiliar social situations
☐Is easily led by others
☐Has difficulty participating in organized activities (sports)
☐Avoids competitive situations
☐Concerns about sexual identity
☐Behaves like the opposite sex
☐Sexually promiscuous
☐Inappropriate sexual behavior (Explain)

☐Sleep difficulties (sleepwalking, restless, inability to fall asleep or sleeps too much)
☐Eating difficulties (has difficulty keeping food down, overeats, does not have much of an appetite, fear of trying new foods, tremendous concern about weight)
☐Poor personal hygiene (does not keep self clean or take an interest in appearance)
☐Enuretic (urinates during the day or night on self)
☐Encopretic (soils self)
☐Tics (sudden rapid, recurrent motor movements or vocalizations)

PSYCHIATRIC/PSYCHOLOGICAL/MEDICAL HISTORY

List all doctors and mental health professionals who have examined and/or treated your child.
Please give name and phone number for each.

Family Physician/Pediatrician _____

Previous Psychiatrist(s) _____

Therapist(s) or Counselor(s) _____

Other Physician(s) _____

Other (list type of provider and contact information) _____

List all previous psychiatric diagnoses given _____

List all other medical conditions/diagnoses _____

List medications your child has been on in the past (not currently taking) for mood or behavior. Please include length of time taken and dose, if known. Please refer to the medication list at the end of this document, if needed.

Medication	Dose	Taken for how long?	Reason for stopping

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What medication(s) is your child taking now? Please include all medications, not just those for mood or behavior. Please refer to the medication list at the end of this document, if needed.

Medication	Dose	Taken for how long?	Reason for taking

List any allergic reactions to medications _____

List any allergies that your child may have and how they are treated _____

If your child has ever been **hospitalized** please explain when and for what reason.

Name of Hospital	Year	Reason/Diagnosis

Please check if any of the following pertain to your child and explain (use text box below)

☐Heart Disease	☐Nausea or vomiting	☐Concussions
☐Lung Disease	☐Drug or alcohol abuse	☐Genetic Syndrome
☐Liver Disease	☐Diarrhea (frequently)	☐Neurological testing
☐Jaundice	☐Diabetes	☐High fevers
☐Seizures	☐Tonsillectomy	☐Injuries or broken bones
☐Fainting	☐Orthodontia	☐Accident prone
☐Asthma	☐Skin Disease	☐Activity limitations
☐Dietary problems	☐Irregular Sleep Patterns	☐Snoring
☐Hearing problems	☐Visual problems	☐Speech problems
☐Urinary problems	☐Bowel or elimination problems	☐Other

Explain any checkmarks above

GYNECOLOGY

☐Pregnancy
☐Abortion (if so, when)
☐Miscarriage (if so, when)
☐Menstrual problems
☐Birth control (if so, what type)

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FAMILY MEDICAL/PSYCHIATRIC HISTORY

Please check which, if any, of the following conditions/problems apply to your child's blood relatives. If other significant medical/psychiatric problems are present among blood relatives, please list those in the space provided below.

	Child's Mother	Child's Father	Child's Brother(s)	Child's Sister(s)	Child's Maternal Grandma	Child's Maternal Grandpa	Child's Paternal Grandma	Child's Paternal Grandpa
Childhood behavior problems	☐	☐	☐	☐	☐	☐	☐	☐
Problems with aggression	☐	☐	☐	☐	☐	☐	☐	☐
ADHD/ Attentional problem	☐	☐	☐	☐	☐	☐	☐	☐
Learning disability	☐	☐	☐	☐	☐	☐	☐	☐
Failed high school	☐	☐	☐	☐	☐	☐	☐	☐
Intellectual Disability	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐
Psychosis/schizophrenia	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Depression (greater than 2 weeks)	☐	☐	☐	☐	☐	☐	☐	☐
Suicide	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety or adjustment disorder	☐	☐	☐	☐	☐	☐	☐	☐
Panic disorder	☐	☐	☐	☐	☐	☐	☐	☐
Other mental disorder (describe below)	☐	☐	☐	☐	☐	☐	☐	☐
Tic disorder or Tourette's	☐	☐	☐	☐	☐	☐	☐	☐
Heart Problem at a young age (<60)	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Antisocial behavior (assault/thefts)	☐	☐	☐	☐	☐	☐	☐	☐
Arrests/incarcerations	☐	☐	☐	☐	☐	☐	☐	☐
Physical abuse (victim)	☐	☐	☐	☐	☐	☐	☐	☐
Physical abuse (perpetrator)	☐	☐	☐	☐	☐	☐	☐	☐
Sexual abuse (victim)	☐	☐	☐	☐	☐	☐	☐	☐
Sexual abuse (perpetrator)	☐	☐	☐	☐	☐	☐	☐	☐

Other significant medical/psychiatric conditions in the family

Name of person completing this form: _____

Relationship to child: _____

I do certify that all the above information is true and complete.

NAME (typed name constitutes e-signature) _____

DATE _____

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PSYCHOTROPIC MEDICATION LIST (for reference)

ANTIDEPRESSANTS

- ☐ Amitriptyline (Elavil)
- ☐ Notriptyline
- ☐ Imipramine
- ☐ Clomipramine (Anafranil)
- ☐ Desipramine
- ☐ Doxepin
- ☐ Amoxapine
- ☐ Fluoxetine (Prozac)
- ☐ Citalopram (Celexa)
- ☐ Escitalopram (Lexapro)
- ☐ Paroxetine (Paxil)
- ☐ Sertraline (Zoloft)
- ☐ Fluvoxamine (Luvox)
- ☐ Venlafaxine (Effexor)
- ☐ Desvenlafaxine (Pristiq)
- ☐ Duloxetine (Cymbalta)
- ☐ Vortioxetine (Brintellix)
- ☐ Vilazodone (Viibryd)
- ☐ Bupropion (Wellbutrin)
- ☐ Mirtazapine (Remeron)
- ☐ Phenelzine (Nardil)

MOOD STABALIZERS

- ☐ Valproic Acid (Depakote)
- ☐ Lamotrigine (Lamictal)
- ☐ Carbamazepine (Tegretol)
- ☐ Oxcarbazepine (Trileptal)
- ☐ Topiramate (Topamax)
- ☐ Gabapentin (Neurontin)
- ☐ Lithium

ANXIETY MEDICATIONS

- ☐ Alprazolam (Xanax)
- ☐ Clonazepam (Klonopin)
- ☐ Lorazepam (Ativan)
- ☐ Diazepam (Valium)
- ☐ Chlordiazepoxide (Librium)
- ☐ Oxazepam (Serax)
- ☐ Hydroxyzine (Vistaril)
- ☐ Buspirone (Buspar)
- ☐ Pregabalin (Lyrica)

ANTIPSYCHOTICS

- ☐ Risperidone (Risperdal)
- ☐ Quetiapine (Seroquel)
- ☐ Olanzapine (Zyprexa)
- ☐ Ziprasidone (Geodon)
- ☐ Clozapine (Clozaril)
- ☐ Aripiprazole (Abilify)
- ☐ Paliperidone (Invega)
- ☐ Asenapine (Saphris)
- ☐ Iloperidone (Fanapt)
- ☐ Caripraszine (Vraylar)
- ☐ Brexpiprazole (Rexulti)
- ☐ Haloperidol (Haldol)
- ☐ Fluphenazine (Prolixin)
- ☐ Pimozide (Orap)
- ☐ Chlorpromazine (Thorazine)
- ☐ Perphenazine (Trilafon)
- ☐ Thioridazine
- ☐ Thiothixene (Navane)
- ☐ Trifluoperazine (Stelazine)

ADHD MEDICATIONS

- ☐ Adderall
- ☐ Vyvanse
- ☐ Dexedrine
- ☐ Methylphenidate (Ritalin)
- ☐ Concerta
- ☐ Focalin
- ☐ Adzenys XR (Amphetamine)
- ☐ Quillivant XR (Methylphenidate)
- ☐ Bupropion (Wellbutrin)
- ☐ Atomoxetine (Strattera)
- ☐ Clonidine (Catapres, Kapvay)
- ☐ Guanfacine (Tenex, Intuniv)

SLEEP MEDICATIONS

- ☐ Melatonin
- ☐ Diphenhydramine (Benadryl)
- ☐ Trazodone
- ☐ Zolpidem (Ambien)
- ☐ Zaleplon (Sonata)
- ☐ Eszopiclone (Lunesta)
- ☐ Ramelteon
- ☐ Triazolam (Halcion)
- ☐ Temazepam (Restoril)