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CLINICAL PSYCHOLOGY ~ GENERAL PSYCHIATRY ~ CHILD AND ADOLESCENT PSYCHIATRY

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CHILD AND ADOLESCENT PATIENT HISTORY FORM

Provider: Gabriela DePrima, Psy.D.
Licensed Clinical Psychologist
PY # 8009

Appointment Date: ___/____/___________
Today's Date: ___/_____/___________

IDENTIFICATION

1. CHILD' NAME: ___________________NICKNAME: ____________________ BIRTHDATE: ___/_____/__________

AGE: ______ PERSON COMPLETING THIS FORM: ___________________ RELATIONSHIP TO CHILD: _________________________

2. MOTHER'S NAME: ____________________________ BIRTHDATE: ___/_____/_________ AGE: ________

HOME PHONE: (__)__________________CELL PHONE: (__)________________ WORK PHONE: (__)________________________

ADDRESS: ____

CURRENTLY EMPLOYED: □ NO □ YES, AS: ___________________________ , EMPLOYER: _____________________________________

3. FATHER'S NAME: ____________________________ BIRTHDATE: ___/_____/_________ AGE: ________

HOME PHONE: (__)__________________CELL PHONE: (__)________________ WORK PHONE: (__)________________________

ADDRESS: ____

CURRENTLY EMPLOYED: □ NO □ YES, AS: ___________________________ , EMPLOYER: _____________________________________

4. PARENTS ARE CURRENTLY: □ MARRIED □ DIVORCED □ REMARRIED □ NEVER MARRIED □ OTHER: ___________

CHILD'S CUSTODIAN/GUARDIAN: ____

5. IF PARENT'S ARE LIVING APART (SEPARATED OR DIVORCED) IS THE OTHER PARENT AWARE THAT YOU ARE SEEKING PSYCHOLOGICAL SERVICES FOR YOUR CHILD? □ NO □ YES

PRESENTING CONCERNS

1. WHO WERE YOU REFERRED BY: ____

2. WHAT ARE YOUR CONCERNS FOR YOUR CHILD?

____

____

____

____

____

____

PRESENTING CONCERNS (CONTINUED)

3. HOW LONG HAVE YOU BEEN AWARE OF THESE CONCERNS?

____

____

____

PSYCHOLOGICAL/PSYCHIATRIC HISTORY

PLEASE INDICATE WHAT TYPE OF TREATMENT YOUR CHILD HAS RECEIVED IN THE PAST.

1. THERAPY? □ NO □ YES, FILL OUT BELOW.

PROVIDER NAME: ____________________________ PHONE: (___) ______________________

DATES OF TREATMENT: ____________________________ REASONS FOR SEEKING TREATMENT: _____________________________

2. MEDICATION MANAGEMENT: □ NO □ YES, FILL OUT BELOW.

PROVIDER NAME: ____________________________ PHONE: (___) ______________________

DATES OF TREATMENT: ____________________________ REASONS FOR SEEKING TREATMENT: _____________________________

3. PSYCHOLOGICAL TESTING? □ NO □ YES, FILL OUT BELOW.

PROVIDER NAME: ____________________________ PHONE: (___) ______________________

DATES OF TESTING: ____________________________ REASONS FOR SEEKING TESTING _____________________________

4. PSYCHIATRIC HOSPITALIZATION □ NO □ YES, FILL OUT BELOW.

FACILITY/HOSPITAL: ____________________________ PHONE: (___) ______________________

DATES OF TREATMENT: ____________________________REASONS FOR HOSPITALIZATION: _________________________________

5. RESIDENTIAL TREATMENT □ NO □ YES, FILL OUT BELOW.

FACILITY/HOSPITAL: ____________________________ PHONE: (___) ______________________

DATES OF TREATMENT: ____________________________REASONS FOR HOSPITALIZATION: _________________________________

MEDICATIONS: PLEASE LIST ALL MEDICATIONS OR SUPPLEMENTS TAKEN BY YOUR CHILD. *INCLUDE PSYCHIATRIC AND MEDICAL MEDICATIONS.*

MEDICATIONS	DOSE	INSTRUCTIONS	PRESCRIBED FOR?
1.____________________	_________	__________________	______________________________
2.____________________	_________	__________________	______________________________
3.____________________	_________	__________________	______________________________
4.____________________	_________	__________________	______________________________
5.____________________	_________	__________________	______________________________

Parent/Guardian-Rated DSM-5 Level 1 Cross-Cutting Symptom Measure-Child Ages 6-17

Instructions: (to Parent or Guardian of the Child): The questions below ask about things that might have bothered your Child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past Two (2) Weeks.**

		During the **past two weeks**, how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** several Days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain (Office Use Only)**
I	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II	3.	Had problems sleeping-that is trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV	5.	Had less fun doing things than he/she use to?	0	1	2	3	4	
	6.	seemed sad or depressed for several hours?	0	1	2	3	4	
V and VI	7.	Seemed more Irritated or Easily Annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII	9.	Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
	10.	Sleeping less than usual for him/her but still has lots of energy?						
VIII	11.	Said he/she felt nervous, anxious or Scared?	0	1	2	3	4	
	12.	Not being able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done because they made him/her feel nervous?	0	1	2	3	4	
IX	14.	Said he/she heard voices-when there was no one there-speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake-that is, saw something or someone that no one else could see?	0	1	2	3	4	

		During the past two weeks, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** several Days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain (Office Use Only)**
X	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
In the past TWO (2) Weeks, has your child….								
XI	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	Yes		No	Don't Know		
	21.	Smoked a cigarette, a cigar or pipe, or used snuff or chewing tobacco?	Yes		No	Don't Know		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamines (like speed)?	Yes		No	Don't Know		
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids?	Yes		No	Don't Know		
XII	24.	In the past TWO (2) Weeks, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	Yes		No	Don't Know		
	25.	Has he/she EVER tried to kill himself/herself?	Yes		No	Don't Know		

Medical History

1. Pediatrician: ______________________________ Clinic/Group Name: _________________________

Phone: (__) ___________________ Address: ____

2. Current Medical conditions/Treatment (e.g., Asthma, Seizures, Diabetes…Etc.)

____

____

____

3. Date of last Check-Up? ______________________ Findings? _______________________________

4. What is your child's Present Health? □ Excellent □ Good □ Fair □ Poor

Please Explain? ____

5. Allergies? □ No □ Yes, They Include (Respiratory, Environmental, Food, Medication):

____

____

6. Past Surgeries?	Date	Location/hospital
1.___________________	_________	___________________________________
2.___________________	_________	___________________________________
3.___________________	_________	___________________________________

7. Past Hospitalizations?	Date	Location/Hospital
1.___________________	_________	___________________________________
2.___________________	_________	___________________________________
3.___________________	_________	___________________________________

Developmental History

1. Mother's Age During Pregnancy? ______________ Health During Pregnancy: ______________________

2. Describe any Complications during Birth or Pregnancy:

____

____

3. Maternal drug, Alcohol, or Tobacco use during Pregnancy? □ No □ Yes, Describe Below:

____

____

4. Approximate Weight at Birth: __________ Months Carried: _____________ Delivery Type: _____________

5. Describe your Child's Health during and after Pregnancy: ___________________________________

Developmental History (Continued)

6. Describe your child as a baby:

____

____

____

7. Provide approximate **AGES** for the following:

Sat Up: ______________ Walked: __________________ Stopped Bottle/Breast Feeding: _________________

Toilet Trained: ________________ Age Said First Word: ______________ talked in Sentence: _________________

8. what language(s) does your Child Speak and what is primary? ______________________________________

Family History

1. Who lives in the Child's Home? ____

2. Does your child have a second home where they spend part of the week? □ No □ Yes, Describe Below:

____

3. How long have parents been married (If Applicable)? __________

4. Mother's Information:

Educational level: ________________________ Medical History: _______________________________________

Psychiatric History: ____

5. Father's Information:

Educational level: ________________________ Medical History: _______________________________________

Psychiatric History: ____

6. Step-Parent(s) (If Applicable)|

Name: _______________________ Date of Birth: ___/_____/____________ Age: ____________________

Educational Level: _________________________ Occupation/Employment: ______________________________

Medical History: _______________________________________ Psychiatric History: ______________________________

Name: _______________________ Date of Birth: ___/_____/____________ Age: ____________________

Educational Level: _________________________ Occupation/Employment: ______________________________

Medical History: _______________________________________ Psychiatric History: ______________________________

8. Siblings

Name	AGE	Relationship	Medical Problems?	Psychiatric Problems?
___________	________	__________________________	_____________________	________________________
___________	________	__________________________	_____________________	________________________
___________	________	__________________________	_____________________	________________________
___________	________	__________________________	_____________________	________________________

FAMILY HISTORY (CONTINUED)

PLEASE INDICATE IF THERE IS A FAMILY HISTORY OF THE FOLLOWING CONDITIONS AND WHO IS AFFECTED BY THE CONDITION:

CONDITION / RELATIONSHIP	CONDITION / RELATIONSHIP

ANXIETY: ______________________________ ________ AUTISM: ____

DEPRESSION: ___________________________________ ADHD: ____

BIPOLAR DISORDER __________________________________ ALCOHOLISM: ____

EATING DISORDERS: __________________________________ DRUG ABUSE: ____

LEARNING DISABILITIES: ______________________________

OTHER PSYCHIATRIC CONDITIONS?

____

____

EDUCATIONAL HISTORY

1. CURRENT SCHOOL: _______________________________ COUNTY/SCHOOL DISTRICT: ___________________________________

PHONE NUMBER: (____)______________________ GRADE: ___________________ TEACHER (S): ______________________________

____

2. DOES YOUR CHILD HAVE AN IEP OR SECTION 504 PLAN? □ NO □ YES, DESCRIBE BELOW:

____

3. IS YOUR CHILD IN SPECIAL EDUCATION CLASSES? □ NO □ YES, DESCRIBE BELOW:

____

4. DOES YOUR CHILD RECEIVE SPEECH, OCCUPATIONAL OR PHYSICAL THERAPY AT SCHOOL? □ NO □ YES, DESCRIBE BELOW:

____

5. HAS YOUR CHILD EVER BEEN SUSPENDED OR EXPELLED FROM SCHOOL? □ NO □ YES, DESCRIBE BELOW:

____

6. HAS YOUR CHILD REPEATED A GRADE? □ NO □ YES, WHICH GRADE(S)?

____

7. IN WHAT SCHOOL SITUATIONS OR SUBJECTS DOES YOUR CHILD PERFORM BEST? WORST?

____

8. WHAT KIND OF GRADES DOES YOUR CHILD EARN?

____

9. IS THERE ANY FAMILY MEMBER WHO PRESENTLY OR IN THE PAST HAVE (OR HAD) LEARNING DIFFICULTIES OR WAS IN SPECIAL CLASSES? □ NO □ YES, WHO AND WHAT KIND/TYPE?____

Educational History (Continued)

10. Age your child began daycare or preschool? _______________ Age started Kindergarten? _________________

11. Please list schools your child has attended (include nursery/daycare if applicable):

Name	City	Grades(s)	Reason for Leaving

____

____

____

____

____

Social history

1. Child's Interest and Hobbies: ____

2. Is your child involved in extracurricular activities? □ No □ Yes, Describe Below:

____

____

3. Does your child have close friends? □ No □ Yes, Describe Below:

____

____

4. Please describe your child's strengths:

____

____

____

5. Please describe your child's Weaknesses:

____

____

____

Goals/Expectations for treatment:

1. Please describe what are your goals/expectations from treatment:

____

____

____