Date Revised:	5/23/11

CHILD'S HEALTH & PSYCHIATRIC HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*:		**Gender:**	☐M ☐F	**DOB:**	

Biological Family History

Please circle any of the conditions below that have occurred in any blood relative and write any more information
☐*Check here is family history is unknown*

Medical:

☐Anemia ☐Allergies ☐Asthma ☐ Birth defects ☐ Bleeds Easily ☐ High Blood Pressure ☐ Diabetes ☐Epilepsy or seizures

☐ Heart problems under 60 ☐ Kidney problems ☐Other:

Psychiatric:

☐Bipolar ☐ Mood Disorder ☐Schizophrenia ☐Depression and/or Anxiety ☐ADHD ☐ Substance Abuse

☐Other:

Medical Information:

Has child been seen by a healthcare provider for any medical issue in the last 3 months? ☐**Yes** ☐**No**

If yes, please list:

Has the child seen a *medical* specialist for any reason in the past (ex: allergist, neurologist)? ☐**Yes** ☐**No**

If yes, please list:

Does the child experience any of the following?

☐Eczema ☐Acne ☐Constipation ☐ Bedwetting ☐ Daytime wetting

☐Obesity/Weight Problems ☐Diabetes ☐Asthma ☐Stool accidents or Smearing

☐Frequent Physical Complaints. If yes, please list:

☐Sleep Problems. If yes, please list:

Has the child been hospitalized for any *medical* (not psychiatric) reason in the past? ☐**Yes** ☐**No**

If yes, please list:

Has the child had surgery in the past? ☐**Yes** ☐**No**

If yes, please list:

Please list medications child is currently taking (Please include dosage and times taken):

Medication	*Dosage*	*Instructions*

Does this child have any ALLERGIES to Medications, Foods, or Environmental Substances? ☐**Yes** ☐**No**

If yes, please list allergy and reaction below:

Allergy	*Reaction*

Has a health care provider ordered a special diet for this child? ☐**Yes** ☐**No**

If yes, please list:

Child's Psychiatric History
Has the child had exposure to any of the following (Please circle all that apply)
☐Physical Abuse ☐ Sexual Abuse ☐ Neglect ☐Domestic Violence ☐ Other Please describe:
Current Psychiatric/Behavioral Concerns:
☐Inattention/hyperactivity ☐Mood instability ☐ Aggression ☐Noncompliance ☐ Other Please describe:
Has the child had any other psychiatric diagnoses other than those listed on the application? ☐**Yes** ☐**No**
If yes, please list diagnoses and provide date of diagnosis below:

Diagnosis:	*Date Given:*

What medications have been used in the PAST? ☐**Check here if medications have never been used.**

Name of medication	*Reason Stopped*	*Dates used*

Please provide information from any previous psychiatric hospitalizations. ☐**None**

Hospital	*Reason for admission*	*Dates*

Primary Doctor Information	
Name:	
Address:	
Phone:	Fax:

Please attach a current copy of child's immunization record.

Signature of Legal Guardian	**Date:**