



Patient/Child's Name: _____ **Date:** _____

Your Name: _____ **Relationship to child:** _____

PSR: Vital signs
Height:
Wt:
BP:
Pulse:

In your own words, please describe the reason for this visit and your child's current difficulties and symptoms:

How long has this been going on? _____

What makes these symptoms better or worse? _____

How has this affected your child's life? _____

What are your goals for treatment? _____

Psychiatric History:

Please list any other mental health providers: _____

Previous mental health diagnoses: _____

Has your child ever been hospitalized for Mental Health Illness or to a rehab facility?

____ Yes ____ No *If Yes when and what for:

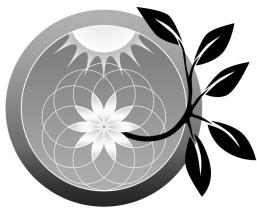
Has your child ever attempted Suicide? ____ Yes ____ No * If yes, when and how?

Has or does your child use any of the following (mark all that apply): () Cannabis () Alcohol
() Nicotine / vaping () Narcotics/Pain Killers () Other Illicit Drugs or street drugs:

Is there a history of trauma or abuse (physical, sexual, other) ? ____ Yes ____ No * If yes, when & how?

Has your child ever been charged/arrested before ? ____ Yes ____ No * If yes, when and what for?

Is there any access to any firearms? ____ Yes ____ No. * If yes, where? _____



Medical History:

Illnesses, complications, medications or substance use during pregnancy and delivery:

Difficulties or complications post-delivery, early development:

List all current medical problems: _____

Surgical and hospitalization history: _____

Does your child have any allergies? Please list source and reaction _____

List of medications currently taken:

Family History:

Has anyone in your child's family been diagnosed with any of the following (mark all that apply):

- () Bipolar Disorder () Anger/Violence () Depression () Post-traumatic Stress Disorder
() ADHD () Autism () Learning, developmental, or Intellectual differences () Eating Disorder
() Schizophrenia () Anxiety () Alcohol Abuse () Other substance abuse/addiction
() Attempted or completed suicides () Legal problems () Domestic violence

History of medication used in the treatment of the above?

Social History:

Where was your child born and raised?

Who lives at home and how are they related? _____

Parent's marital status: () Married () Separated/Divorced Custody: _____

Does anyone in your child's home use any of the following (mark all that apply): () Cannabis
() Nicotine () Alcohol () Narcotics/Pain Killers () Other Illicit Drugs or street Drugs:

Describe any legal problems for your child or others in the home: _____



Parent's employment: _____

Child's School: _____ Grade Level: _____ Repeats or difficulties: _____

Child's average grades and performance: _____

Hours of screen time/day, and what does he/she do? _____

Cultural and religious considerations: _____

List any additional supports/services from school or the community that your child receives:

Physical Symptoms as of Today:

- Headache Fatigue Weight Changes Fever Chills Sudden Vision Changes Sinus problems Sudden Hearing Changes Ringing in your Ears Throat problems Cough Chest pain/discomfort Shortness of Breath Frequent Urination Difficulty starting urine stream Low Sex Drive Erectile Dysfunction Nausea Vomiting Diarrhea Constipation Muscle or Joint pain Numbness/Tingling Cold intolerance Heat intolerance

Women: Unusual discharge or bleeding Menopause Date of last period: _____

Other: