AHB Center
FOR BEHAVIORAL HEALTH AND WELLNESS
An Integrative, Compassionate, Personalized Approach

Child/Adolescent History Form

Please complete this confidential form to help us better understand you and your child's concerns.

Child's Name: _____ Age: _____

Date of Birth: _____ Gender: _____

Current Grade: _____ Current School: _____

Family Information

Parent's marital status (check all):

- ☐ single, never married
- ☐ married
- ☐ separated; when:_____
- ☐ divorced; when:_____
- ☐ widowed; when:_____
- ☐ remarried; when: _____

Parent's full name: _____
Parent's age/occupation: _____
Parent's # years of education _____
Parent's full name: _____
Parent's age/occupation: _____
Parent's # years of education _____
Guardian's full name: _____
Guardian's age/occupation: _____

If parents are divorced, who has physical custody of this child? _____
Who has legal custody of this child? _____

Please check any of the following that are true for this child:

- ☐ was adopted If so, is child aware ☐ yes ☐ no Age at adoption: _____
- ☐ is a foster child If so, since when _____

Who lives in home with child? (mother, father, stepparent, parent's significant other, brothers and sisters, aunts, uncles, grandparents, foster parents, etc.)

Name	Age	Relation to child

Pregnancy History

Please check any of the following, which occurred during the mother's pregnancy with this child.

- ☐ did not receive prenatal care
- ☐ gestational diabetes
- ☐ hypertension/high blood pressure
- ☐ depression, anxiety
- ☐ toxemia
- ☐ anemia (low iron)
- ☐ RH incompatibility
- ☐ infection _____
- ☐ smoking cigarettes
- ☐ alcohol use
- ☐ prescription drug use type:_____
- ☐ other drug use type:_____
- ☐ physical injury/trauma
- ☐ hospitalization during pregnancy
- ☐ surgery during pregnancy _____
- ☐ other _____

Child's Birth and Postnatal History

Born: _____ weeks early ☐ on-time _____weeks late
Apgar Scores, if known _____

Birth and delivery:

- ☐ no complications
- ☐ caesarean section
- ☐ multiple births
- ☐ cord around neck
- ☐ forceps/vacuum assisted
- ☐ other _____

How much did baby weigh? _____
How long did baby stay in hospital? _____
Please check any of the following, which applied during the two months after birth:

- ☐ stay in intensive care nursery
- ☐ breathing problems
- ☐ jaundice (skin yellow)
- ☐ cyanosis (skin blue)
- ☐ convulsions/seizures
- ☐ feeding problems
- ☐ injury
- ☐ surgery _____
- ☐ physical deformities
- ☐ given medications type: _____
- ☐ excessive crying
- ☐ sleeping problem
- ☐ very inactive
- ☐ very jittery
- ☐ other: _____

Developmental History

As closely as you can recall, please write the age when your child did the following:

_____ sat up without support
_____ crawled
_____ walked alone
_____ gave up bottle/breast
_____ spoke first word
_____ used short sentences
_____ toilet-trained (day)
_____ toilet-trained (night)
_____ dressed him/herself
_____ drew a circle

Child's Medical History

Please check any of the following that the child has had since birth.

- ☐ Allergies (type: _____)
- ☐ Asthma
- ☐ Bowel problems: _____
- ☐ Chronic pain
- ☐ Diabetes (☐ Type 1 ☐ Type II)
- ☐ Eye and/or vision problems
- ☐ Endocrine problems: _____
- ☐ Genetic disorder: _____
- ☐ Head injuries &/or concussions
- ☐ Headaches &/or migraines
- ☐ Hearing loss
- ☐ Other: _____
- ☐ Infections (☐ TB, ☐ CMV, ☐ HIV)
- ☐ Lead exposure/poisoning
- ☐ Meningitis &/or Encephalitis
- ☐ Recurrent ear infections/tubes
- ☐ Seizures
- ☐ Serious injury: _____
- ☐ Slow weight gain
- ☐ Surgery: _____
- ☐ Testing: ☐ EEG, ☐ MRI, ☐ CT
- ☐ Thyroid problems: ☐ hypo ☐ hyper
- ☐ Hospitalization: _____
- ☐ Other: _____
- ☐ Illness: ☐ Chicken pox, ☐ Whooping cough, ☐ Measles, ☐ Mumps, ☐ Scarlet Fever

What medication(s) has your child taken or is now taking?

Medication	Dates	Reason	Effectiveness

Daycare/School Information

Please fill in the following information, including daycare:

School	Dates (or ages) attended

Has your child ever repeated a grade, been retained, or held back? ☐ yes ☐ no
If so, what grade(s)? _____

Your child's current academic performance:
☐ Above grade level ☐ On grade level ☐ Below grade level ☐ Inconsistent

Please check any of the following services that your child has ever received.

☐ IEP ☐ 504 Plan since: _____ Area: _____
☐ AIG: ☐ Reading ☐ Math ☐ occupational therapy (OT)
☐ self-contained classroom at school ☐ physical therapy (PT)
☐ speech/language therapy (SP/L) ☐ other: _____

Prior Counseling/Treatment Information

Please list any prior diagnoses:

Diagnosis	Dates (or ages)

Please fill in the following information, regarding past mental health services:

Therapy/Hospitalizations/Community Support/Groups	Dates (or ages)

Behavioral Patterns

Please check and/or circle any of the following that has **ever** been true of your child:

☐ Extremely restless/hyperactive
☐ Clingy/wants to be held too often
☐ Extreme reaction to tastes/being touched
☐ Difficulty being consoled/calmed
☐ Extreme reaction to noises
☐ Seems too sad
☐ Seems too happy
☐ Seems like a "worry-wart"
☐ Very irritable/moody
☐ Frequent/unpredictable angry outbursts
☐ Head banging
☐ Cutting/self-harm
☐ Eating disorder
☐ Bedwetting/toileting accidents after 5
☐ Sleep Difficulties
☐ Memory problems
☐ Rocking of body
☐ Aggressive towards others
☐ Damages property
☐ Trouble making eye-contact
☐ Is not affectionate
☐ Making odd sounds, noises
☐ Seems like they hear voices/see things
☐ Does not play with other children
☐ Does not seem to pay attention
☐ Sexualized language or behavior
☐ Talks about suicide/wanting to hurt self
☐ Drug use
☐ Hallucinations
☐ Other: _____
☐ Other: _____
☐ Other: _____

Has your child ever been exposed to trauma or violence? ☐ yes ☐ no

If so, explain: _____

Approximately how many hours per day does your child play with media (e.g., watch TV/play video games or on cell phone)? _____
Approximately how many hours per day does your child spend completing homework? _____
Approximately what time does your child go to bed at night? _____ Awake? _____

Describe special areas of interest or hobbies (e.g., art, reading, sports, church activities, scouts, etc.).

Activity	How much time per week?	How long participated?

Please check any of the following events that have happened for anyone in the family in the past 6 months.

- ☐ increase in marital/relationship conflict
- ☐ separation or divorce
- ☐ remarriage
- ☐ death in family
- ☐ substance abuse
- ☐ loss of job/job stress
- ☐ change in living situation
- ☐ trauma or injury
- ☐ serious illness/hospitalization
- ☐ new baby
- ☐ jail sentence/legal trouble
- ☐ financial stress
- ☐ other _____
- ☐ other _____

Family Background

Indicate if any of the child's relatives have had any of the following conditions, and write that person's relationship to the child next to it. By relatives, we mean parents, brothers, sisters, grandparents, aunts, uncles, and cousins on both sides.

	Condition	Relationship to child
☐	convulsions, seizures, epilepsy	
☐	speech problems	
☐	learning problems in reading, writing, math	
☐	retained/held back in school	
☐	autism/Aspergers	
☐	mental retardation	
☐	hyperactive as a child or (ADD/ADHD) Attention-Deficit/Hyperactivity Disorder	
☐	depression	
☐	anxiety	
☐	Bipolar (manic-depression)	
☐	eating disorder	
☐	other mental illness _____	
☐	suicide attempts	
☐	alcohol or substance abuse/addiction	
☐	thyroid disease (hyperthyroidism/hypothyroidism)	
☐	Other _____	

Thank you. We look forward to working with you and your family.