INDEPENDENT BEHAVIORAL HEATLH GROUP
CHILD/ADOLESCENT CONFIDENTIAL HISTORY

TO BE COMPLETED BY THE PARENT/GUARDIAN

Patient Name____Date of Birth ______________________

Adopted: [ ] Natural: [ ] Place of Birth: ____

Where is/was the Child/Adolescent
Raised?____

Current Height: __________________ Current Weight: ___________________

FAMILY

	Name	Date of Birth	City/State of Residence	Lives with the Minor?	If deceased; date, age, cause of death
Biological Mother				**Yes or No**	
Biological Father				**Yes or No**	
Step/Adoptive Mother				**Yes or No**	
Step/Adoptive Father				**Yes or No**	

OTHER ADULTS RESIDING WITH THE MINOR:

Name	Relationship to Minor	Education	Occupation

BROTHERS AND SISTERS:

Name	Current Age	Natural, Step, Half or Adopted	Lives with Minor
			Yes or No
			Yes or No
			Yes or No
			Yes or No
			Yes or No
			Yes or No

OTHER CHILDREN RESIDING WITH THE MINOR:

Name	Age	Relationship

Patient Name____ DOB____________________

Biological parents' date of marriage, if applicable: ______________________Date of divorce, if applicable: _________________________________

Remarriages and dates: Mother: ____

Father: ____

INPUT OF PATIENT OR FAMILY

State in your own words the nature of the child/adolescent's present problems and previous difficulties: ____________________________________

____

____

When were the problems/difficulties first noticed and by whom (i.e. doctor, family member, friend, teacher)?_________________________________

____

____

What do you want the clinic to help your child/adolescent accomplish?

Short Term?____

____

Long Term?____

____

____

____

Describe the child/adolescent's positive qualities, strengths, aptitudes and interests: ____

____

PERSONAL HISTORY

During Pregnancy:	
Rh Problems?	**Yes or No**
Alcohol, drug use?	**Yes or No**
Diabetes?	**Yes or No**
Toxemia?	**Yes or No**
Length of term:_________________________________	
During Labor and Birth:	
Hours of labor? 1-3	**Yes or No**
Over 12 Hours of labor?	**Yes or No**

Patient Name____ DOB____________________

Breech Presentation?	Yes or No
Cesarean?	Yes or No
Oxygen Deprivation?	Yes or No
Infections?	Yes or No
Birth Weight? ______________________lbs. _________________oz.	

Other information regarding complications and problems and/or any comments you would like to make regarding the pregnancy

labor and birth: ____

If adopted, list child/adolescent's age at adoption and name of agency facilitating the adoption:

____

EARLY DEVELOPMENT

Feeding problems during infancy? Yes or No If Yes explain:____________________________________
Age toilet training began: ____________months
Age toilet training complete: ____________months
Any problems related to toilet training? Yes or No If Yes explain:____________________________________
Have there been problems with toilet use? Yes or No If Yes explain:____________________________________
Any sleep problems (insomnia, night terrors, excessive sleep, etc.)? Yes or No If Yes explain:____________________________________
Does the child have own bedroom? Yes or No If Yes explain:____________________________________
Does the child share a bedroom? Yes or No If Yes explain:____________________________________
Does the child share a bed? Yes or No If Yes explain:____________________________________
Any delays in developmental milestones (sitting, walking, talking)? Yes or No If Yes explain:____________________________________
Does child tend to play alone? Yes or No If Yes explain:____________________________________
Age at onset of menstruation, if applicable: ___________years
Any menstrual problems? Yes or No If Yes explain:____________________________________
Ever been described as hyperactive or withdrawn? Yes or No If Yes explain:____________________________________
Any gross motor coordination problems (awkwardness, clumsiness)? Yes or No If Yes explain:____________________________________
Any fine motor coordination problems or writing difficulty? Yes or No If Yes explain:____________________________________
Any problems with speech? Yes or No If Yes explain:____________________________________
Any problems with hearing? Yes or No If Yes explain:____________________________________
Any language problems? Yes or No If Yes explain:____________________________________
Any visual or perceptual problems? Yes or No If Yes explain:____________________________________
Have any immunization shots been missed? Yes or No If Yes explain:____________________________________

MEDICAL INFORMATION

Any childhood diseases (measles, mumps, chicken pox)? Yes or No If Yes explain:____________________________________
Any hospitalization(s)? Yes or No If Yes explain:____________________________________
Any disabilities, limitations or ailments at this time? Yes or No If Yes explain:____________________________________
Any convulsive disorder? Yes or No If Yes explain:____________________________________
Any mental disorder in extended family? Yes or No If Yes explain:____________________________________
Any alcohol or drug abuse in extended family? Yes or No If Yes explain:____________________________________
Any involvement with alcohol or illicit drugs by the child/adolescent? Yes or No If Yes explain:____________________________________

Allergies/Sensitivities

Medication Allergies:____
Food Allergies:____
Environmental Allergies:____

Patient Name____ DOB____________________

Is the child experiencing any pain? **Yes or No**

If Yes Area of pain:____

Pain Rating Scale (circle one): |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____

0 1 2 3 4 5 6 7 8 9 10

No Pain Mild Moderate Severe Very Severe Worst Possible

Name and address of family physician: ____

____

Date and reason for most recent visit to a medical doctor: _______________________________________

Date of last physical examination: ____

List names/visit dates of all professionals that have been involved with the problems/difficulties for which treatment is being sought:

____

____

List previous mental health/substance abuse treatment:

Facility/Provider(s)____Date(s)___________________________

Facility/Provider(s)____Date(s)___________________________

Facility/Provider(s)____Date(s)___________________________

SCHOOL/SOCIAL ADJUSTMENT

At what age was school (of any kind) entered?

____

Have there ever been any difficulties in school? ____

____

____

Has minor attended Special Education classes? Yes ______ No _______

If yes, is patient currently attending and when did these services begin?_____________________________.

Current grade level (please circle): K 1 2 3 4 5 6 7 8 9 10 11 12

Name and address of present school: ____

____

Name of school official to contact regarding school performance (contact can be made only after consent is given on a proper Release Form):

____

____

Has there ever been any trouble with the law? Yes ______ No _______

If yes, state instances and dates:____

________Work/Employment

Patient Name____ DOB____________________

history:____

Allergies:
____
____
____

How are you related to this minor? ____

Printed Name of Parent/Guardian completeing history:____

____Date: _____________________________
Parent/Guardian Signature____

____ Date: _____________________________
Therapist Signature

NOTE: This Confidential History Form constitutes a data-gathering document that is part of the patient's Comprehensive or Biopsychosocial Assessment.

Patient Name____ DOB____________________