

PERSONAL AND MEDICAL DATA FORM (child/ adolescent)

Child/ Adolescent's name _____ Today's date _____

Date of birth _____ Age _____ Gender _____ Ethnicity _____

Biological parents: ___ Married ___ Divorced ___ Widowed ___ never married/not together

Biological parents' names: _____

If parents are divorced, what is the legal custody? (circle) Joint Mother has sole Father has sole

Persons living in child's main household: _____

If applicable, persons living in child's 2nd household: _____

Specific Reason for today's visit: _____

Do you have any of the following concerns about your child? ___ Anxiety ___ Depression ___ Anger
___ Doing poorly in school ___ Eating (i.e. anorexia/ bulimia) ___ poor friendships
___ Drugs/ alcohol ___ dramatic mood swings ___ poor attention span ___ hyperactivity

DEVELOPMENTAL/ MEDICAL HISTORY

Age of mother at child's birth: _____ Any problems with the pregnancy? _____

Any exposure to drugs/ alcohol/ medications during pregnancy? _____

Any problems with the delivery? _____

Was child healthy at birth and during infancy? _____

Were developmental milestones achieved by the time listed? (check if yes)

Sitting by 9 months _____ Walking by 15 months _____ Toilet training by 4 years _____

Talking: Babbling by 9 months _____ Several words by 15mos. _____ 2 word sentences by 3 yrs _____

Understandable by 4 yrs _____ Any treatment for speech delay? _____

Tying shoes by 6 yrs _____ Riding 2-wheel bike by 7 years _____

Any history of coordination problems / developmental delay? _____

Has your child ever had any of the following medical problems:

Asthma	___ yes ___ no	Heart problems	___ yes ___ no
Chronic sleep problems	___ yes ___ no	Seizure	___ yes ___ no
Major head injury	___ yes ___ no	Diabetes	___ yes ___ no
Growth problems	___ yes ___ no	Ever been hospitalized	___ yes ___ no
Stomach problems	___ yes ___ no	Tics (eye blinking, etc)	___ yes ___ no

Other significant medical concerns _____

Current medications/ dosages _____

Previous psychiatric medications _____

Medication allergies _____

Does your child have a regular medical provider (pediatrician, etc)? _____ Last visit: _____

The child/ adolescent is generally in the room for the entire evaluation. If there's anything you don't want to share in front of them, please tell me here: