CLIENT HEALTH HISTORY

Client Name:_____

Person completing form (i.e. parent):_____
Relationship:_____

Contact person in case of emergency: _____**Relationship**:_____
Phone #:_____
Primary Care Physician: _____
Date of Last Exam: _____
Current Medical Condition(s):
_____
_____
Any peri-natal or developmental abnormalities? No___ Yes___ (Please explain on back of form)
Is your child currently taking any prescription or "over the counter" medication(s)? No___ Yes___
If Yes, please identify the name, current dosage, and date began for each: _____
_____
Does your child have any allergies? No___ Yes___ If yes, please list: _____
_____
Has your child received any Psychological/Psychiatric treatment before? No___ Yes___
If Yes, please show the total number of outpatient visits they have had: _____
What was their age at the first visit? _____
Have they had any inpatient/hospital treatment for mental health or substance abuse? No___ Yes___
[If Yes, please list facility(ies) date(s) and length(s) of stay(s)]: _____
_____
What caused you to get help for your child now?
_____
_____
_____

_____
Please answer whether or not your child is experiencing any of the following symptoms:

Suicidal Thoughts/Impulses ..... N____ Y____
Homicidal Thoughts/Impulses ..... N____ Y____
Appetite Problems ..... N____ Y____
Sleep Problems ..... N____ Y____
Physical Complaints ..... N____ Y____
Anger/Irritability ..... N____ Y____
Isolation/Social Withdrawal ..... N____ Y____
Anxiety/Panic ..... N____ Y____
Phobia ..... N____ Y____
Bingeing/Purging food ..... N____ Y____
Poor Impulse Control ..... N____ Y____
Violence Toward Others ..... N____ Y____
Destruction of Property ..... N____ Y____
Strange or Unusual Behavior ..... N____ Y____
Confused or Irrational Thinking ..... N____ Y____
Bothersome Repetitive Thoughts or Behaviors N____ Y____
Self-mutilation ..... N____ Y____
Academic Problems N ____ Y ____
School Behavior Problems N ____ Y ____
Drug or Alcohol Use N ____ Y ____
Involvement with Law Enforcement N ____ Y ____