

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 |