Medical History Form | Adolescent

child&familydevelopment

Today's date:

IDENTIFYING INFORMATION:

Child's name:

Date of birth: Age: Yrs. Mos. Sex: M F

School: Grade:

Parent names:

Stepparents involved:

Child lives with:

Other family members (list ages and in/out of home):

Biological siblings:

Step siblings:

Others:

Primary language spoken in home:

REASON FOR REFERRAL:

Referred by:

Reason for visit:

When was the reason first noticed? By whom?

Previous diagnosis (list type and dates):

Previous evaluations (list type and dates):

Current/previous medications:

Current/previous hospitalizations:

Current/previous treatment (list type and dates):

What are your concerns about your child?

What do you hope will be gained by having your child seen at this clinic?

MEDICAL CONTACTS:

Pediatrician: ____________________ Group or practice: ____________________

Other physicians or therapists: ____________________

Name: ____________________ Group or practice: ____________________

Name: ____________________ Group or practice: ____________________

PREGNANCY/BIRTH HISTORY:

Please describe any significant pregnancy or birthing experiences:

CHILDHOOD MEDICAL HISTORY:

Check any of the following that apply. List age and explanation:

Item	✔	Age	Explanation
Convulsions/seizures			
Meningitis			
Encephalitis			
Injury to head			
Fainting spells			
Measles			
Chronic illnesses			
Constipation			
Reflux			
Allergies			
Chronic cough			
Asthma			
Heart disorders			
Stomach or intestinal disorders			
Reactions to immunizations (specify)			
Chronic ear infections			
Hearing exam/poor hearing			
Vision exam/poor eyesight			
Sleep disorders			
Eating disorders			
Other			

FAMILY HISTORY:

Check any of the following that apply. List relationship (i.e. mother, brother), and explanation:

Family history of ...	✔	Relationship	Explanation
Learning disorders			
Emotional disorders			
Genetic disorders			
Attention disorders			
Speech/language disorders			
Substance abuse			
Other			

MOTOR DEVELOPMENT:

Please describe any significant motor development delays or any treatment/therapy received:

____
____
____
____

SPEECH AND LANGUAGE DEVELOPMENT:

Please describe any significant speech, language, eating delays or behaviors as well as any treatment/therapy received:

____
____

ACADEMIC/EDUCATION DEVELOPMENT:

School: ____________________ Phone: ____________________

Address: ____

Grade: ____________________ Teacher: ____________________

Most liked subjects: ____

Least liked subjects: ____

Future goals/plans: ____

____

History:

Schools attended	Years

Check any of the following that apply:

Academic behaviors	✔
Poor physical coordination	
Poor handwriting, letter formation	
Poor memory, short-term and long-term	
Right-left confusion, directionality problems	
Hand dominance established late (_____age) or not at all	
Late letter recognition	
Poor word recognition skills	
Poor reading comprehension	
Poor phonetic base	
Difficulty getting ideas on paper	
Problems in math	
Word problems and calculations	
Poor spelling in day-to-day assignments	
Problems with classwork or homework completion	
Procrastinates	
Forgets assignments/materials	

SOCIAL/EMOTIONAL BEHAVIORAL DEVELOPMENT (continued):

Academic behaviors	✔
Poor attention and concentration	
Trouble keeping materials organized	
Conflict with teacher	
Certified for special education (LD resource help, MR, Speech, etc.)	
Drop in group achievement tests	
Repeated grade – please list which grade(s):	
Expulsion/suspension from school	

SOCIAL/EMOTIONAL BEHAVIORAL DEVELOPMENT:

Who generally disciplines the child? ______________________

What methods are used: ______________________

Do parents agree on methods of discipline? Yes No

If no, describe: ______________________

____

Check any of the following that apply:

Behaviors	✔	Explanation
Difficulty sleeping ☐ / Nightmares ☐		
Enuresis (wetting) ☐ / Encopresis (soiling) ☐		
Difficult to Discipline		
Temper tantrums		
Sad ☐ / Cries easily ☐		
Unusually active, fidgety ☐ / Bites nails ☐		
Unusually inactive, apathetic		
Difficulty with brothers and/or sisters		
Difficulty in getting along with other children		
Lacks age appropriate social interests		
Avoids peer interactions or other unfamiliar social contacts		
Socially inappropriate		
Prefers to be alone		
Inattentive ☐ / Impulsive ☐ / Distractible ☐		
Unrealistic worry and/or pessimistic attitude		
Anxiety ☐ / Separation anxiety ☐		
Panic attacks		
Difficulty with transitions		
Resists changes in environment		
Blames others for own mistakes		
Expresses no remorse		
Lies ☐ / Steals ☐		
Truant ☐ / Excessive absenteeism ☐		
School refusal		
Disregards family or community rules		
Argumentative		
Destructive		

SOCIAL/EMOTIONAL BEHAVIORAL DEVELOPMENT (continued):

Behaviors	✔	Explanation
Has panic attacks		
Has low productivity at school, work, home		
Is chronically tired or irritable		
Has decreased interest in pleasurable activities		
Has thoughts of death or suicide		
Has hallucinations or delusions		
Is socially inappropriate		
Has odd/bizarre ideas		
Has poor personal hygiene		
Is overly dependent/helpless		

Additional comments:

Please note any major changes in your child's family, school, social life in the last 6–9 months, which could be important. If there is any specific information which has not been requested on this form but which would help us in understanding your child's problems, please include here:

Thank you for taking the time to complete this form. It will help us serve your family better. If you have other critical documentation related to your concerns, please bring copies of records to your first appointment.

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