# 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? Joint Mother has sole Father has sole

Persons living in child's main household:___________________________________________________

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

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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

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## 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 issues? ________________________________________

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 _________________________________________________________________

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**Current medications/ dosages** _________________________________________________________

Previous psychiatric medications_____________________________________________________________

Medication allergies ______________________________________________________________________

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

The child/ adolescent is 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: