CHILD (16-) CLIENT HEALTH HISTORY

Client Name:	Date:	Phone:
Person completing form (i.e. parent):	Relationship:	
Contact person in case of emergency:	Relationship:	
Primary Care Physician:	Date of last exam:	
Current medical condition(s):		

Any peri-natal or developmental abnormalities? **YES**_____ **NO**_____

If yes, please explain:

Has your child received any Psychological/Psychiatric treatment before? **YES**_____ **NO**_____

If yes, please show the total number of out-patient visits they have had:

What was their age at the time of first visit?

Have they had any inpatient/hospital treatment for mental health or substance abuse? **YES**_____ **NO**_____

If yes, please list facility(ies), date(s) and length 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	**YES**_____	**NO**_____
Homicidal Thoughts/Impulses	**YES**_____	**NO**_____
Appetite Problems	**YES**_____	**NO**_____
Sleep Problems	**YES**_____	**NO**_____
Physical Complaints	**YES**_____	**NO**_____
Anger/Irritability	**YES**_____	**NO**_____
Isolation/Social Withdrawal	**YES**_____	**NO**_____
Anxiety panic	**YES**_____	**NO**_____
Phobia(s)	**YES**_____	**NO**_____
Binging/Purging food	**YES**_____	**NO**_____
Poor Impulse Control	**YES**_____	**NO**_____
Violence Towards Others	**YES**_____	**NO**_____
Destruction of property	**YES**_____	**NO**_____
Strange or Unusual Behavior	**YES**_____	**NO**_____
Confused or Irrational Thinking	**YES**_____	**NO**_____
Bothersome Repetitive Thoughts Or Behaviors	**YES**_____	**NO**_____
Self-Mutilation	**YES**_____	**NO**_____
Academic Problems	**YES**_____	**NO**_____
School Behavior Problems	**YES**_____	**NO**_____
Drug or Alcohol Use	**YES**_____	**NO**_____
Involvement with Law Enforcement	**YES**_____	**NO**_____

What are your (parent's) goals for treatment of your child?