CHILDREN'S HISTORY FORM

NAME:____

Last First Middle Initial

DOB:_____/_____/_____ AGE:_________ DATE SEEN:__________

INFORMANT:____________________ Relationship To Child:________

Who has legal guardianship of this child?_______________________________

Do all legal guardians request this evaluation?___________________________

WHAT MADE YOU SEEK HELP AT THIS TIME?_______________________

____

PROVIDE BRIEF DESCRIPTION OF MAJOR PROBLEMATIC BEHAVIOR

(including duration and how you have handled it)_____________________________

____

____

____

____

____

HAS THE PATIENT HAD ANY PREVIOUS PSYCHIATRIC/PSYCHOLOGICAL EVALUATIONS /TREATMENTS? (PLEASE ELABORATE)

Date	**Treating Professional**	**Reason**	**Outcome/Medication:**

SIGNS AND SYMPTOMS Has your child had any of the following**?** (Please explain items checked in space provide)

Eating problems (poor appetite/ picky eater/overeats)__________________________

Sleeping problems(insomnia, nightmares , sleepwalking, night terrors)______________

Sadness____________ Irritability _______________ Temper Tantrums ____________

Headaches __________________ Stomachaches_____________________

Other physical complaints not readily explained______________________________

Hyperactivity ________ Poor Concentration ________ Drugs/Alcohol Abuse________

Lying______ Stealing______ Setting Fires______ Tics/Unusual Movements__________

Suicidal Thoughts________ Anxiety/ Fears _____ What? ____________________

Other Repetitive Behaviors (rituals, mannerism, habits), or Problems/ Concern:

____

ANY OTHER AREAS OF CONCERNS:________________________________

____

____

____

BOCA RATON PSYCHIATRIC GROUP, P.A.

PLEASE PRINT **DATE** ______________________

[ ] Dr. [ ] Mr. [ ] Mrs. [ ] Miss [ ] Ms. [ ] Male [ ] Female

AGE _____

MARITAL STATUS: []SINGLE []MARRIED []WIDOWED [] DIVORCED[]SEPARATED

PATIENT'S LAST NAME ________________ FIRST ________________MIDDLE _______________

STREET ADDRESS ____ APT__________________

CITY _________________ STATE_____ ZIP ______________REFERRED BY___________________

EMPLOYER ___________________________ EMPLOYER ADDRESS _________________________

HOME PHONE # _____________________ WORK # ______________CELL#____________________

DATE OF BIRTH _____________SS#_________________ DRIVER LICENSE # __________________

SECONDARY ADDRESS:

____

____

PERSON TO CONTACT IN CASE OF EMERGENCY __________________ PHONE ______________

FINANCIAL RESPONSIBILITY

GUARANTOR'S LAST NAME _________________ FIRST ________________ M_________________

ADDRESS ____________________________ CITY ______________ STATE _______ ZIP __________

DOB _____________________ SS# ___________________ DRIVER LIC #_______________________

EMPLOYER ___________________________________ PHONE ______________________________

IS THIS CASE RELATED TO ANY LITIGATION? []YES []NO
DOES A LAWYER REPRESENT YOU? []YES [] NO

INSURANCE INFORMATION
NAME OF INSURANCE COMPANY ____
PLEASE PRESENT YOUR CARD TO THE RECEPTIONIST

ABUSE/ TRAUMA: Has child ever been physically/ sexually abused? YES☐ No☐
GIVE DETAILS:____
____
____
____

PATIENT'S BIOLOGICAL FAMILY MEDICAL AND PSYCHIATRIC HISTORY: (Fill in details of diagnosis, how related, etc.)

	Maternal Relatives	Paternal Relatives
Alcoholism	______________	______________
Drug Abuse	______________	______________
Mental Illness (type)	______________	______________
Psychiatric Hospitalizations	______________	______________
Mental Retardation	______________	______________
Learning Disabilities	______________	______________
Hyperactivity	______________	______________
Suicide Attempt	______________	______________
Other Medical Illnesses (specify)	______________	______________

PATIENT'S MEDICAL HISTORY (PROBLEMS WHILE MOTHER WAS PREGNANT WITH PATIENT):
Illnesses/Complications:____
Medications taken:____
Tobacco/ Alcohol/Other Drugs (prescription or otherwise):___________________
Length of Gestation (months)____
Delivery (type: e.g., head first, breech): ________________________________
Birth Weight:________________ Apgar rating:________________________
Problems during delivery/ shortly thereafter ______________________________
Medications/ Anesthesia during delivery: _________________________________
Length of stay in hospital:____

CURRENT MEDICATIONS AND DOSES:
____
____
____

SERIOUS INJURIES/ ILLNESSES/ SURGERY IN PAST (high fever, seizures, head injury, etc.)____
____

Allergies
(specify):____

CURRENT PHYSICIANS (name, address, date of most recent physical exam/lab work):____

DEVELOPMENTAL MILESTONES (in months):
First Word_______ Sat alone________ Walked _______ Talked in sentences_______
Weaned ____________ Fed Self__________ Tied own shoes____________________
Toilet training (ease or difficulty: any wetting or soiling afterward)_________________

FAMILY HISTORY: Child lives with: mother________
father___________ adoptive parents________ Other
(specify)______________

	NAME	AGE	EDUCATION	OCCUPATION
MOTHER:				
FATHER:				
SIBLINGS:				
STEPPARENT**:**				

MARITAL HISTORY:

	MOTHER	FATHER
Number of Marriages	___________	__________
Children from previous marriages	___________	__________
Date of most recent marriages	___________	__________
Date(s) of separation(s)	___________	__________

If divorced:
How Long:____
Custody arrangement:________________________________
Visitation schedule:__________________________________
Child's adjustment to divorce:__________________________

Current School____
Phone:_______________________________ **Teacher:**______________________
Special Classes/ SLD/Tract _______________**GRADE**_____________________

____
Signature of person completing form **Date**

BOCA RATON PSYCHIATRIC GROUP, P.A.

I, ______________________________________, am the legal guardian of

___________________________________ and give consent to the **Boca Raton Psychiatric Group** to evaluate and treat ___________________________.

I also give_____________________________________, permission to make decisions regarding treatment in my behalf.

X ____