

**ROCHESTER CENTER FOR BEHAVIORAL MEDICINE**  
**CHILD / ADOLESCENT / PARENT ~ CONFIDENTIAL HISTORY**

Patient's Name \_\_\_\_\_ Date of Clinic Visit \_\_\_\_\_

Male  Female  Nickname? \_\_\_\_\_ Referred By \_\_\_\_\_

Parent's/Guardian's Name \_\_\_\_\_

Home Address \_\_\_\_\_ Parent's Work Address \_\_\_\_\_

\_\_\_\_\_

Home Telephone # \_\_\_\_\_ Work Telephone # \_\_\_\_\_

Patient's Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_ Age \_\_\_\_\_ Natural  Adopted

EMERGENCY CONTACT (Name, Relationship & Telephone #) \_\_\_\_\_

\_\_\_\_\_

**EDUCATIONAL BACKGROUND**

Patient's School and District \_\_\_\_\_ Grade \_\_\_\_\_

Please explain why you are seeking professional assistance for your child. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PARENTS: MARITAL STATUS** (Check all that apply)

MOTHER:      Single     Married     Divorced     Remarried     Widowed     Significant Relationship   
FATHER:      Single     Married     Divorced     Remarried     Widowed     Significant Relationship

If you have a spouse/partner, please provide the following information: (His/Her Age, Years Married or Together & His/Her Education)

\_\_\_\_\_

**PARENTS: EMPLOYMENT**

MOTHER'S JOB / PROFESSION \_\_\_\_\_

FATHER'S JOB / PROFESSION \_\_\_\_\_

CHILD'S FAMILY MEMBERS	Name	Child Lives With?		Age	Quality of the Relationship
		Y	N		
Mother:		<input type="checkbox"/>	<input type="checkbox"/>		
Father:		<input type="checkbox"/>	<input type="checkbox"/>		
Step-Mother:		<input type="checkbox"/>	<input type="checkbox"/>		
Step-Father:		<input type="checkbox"/>	<input type="checkbox"/>		
Siblings:					
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
Grandparents:					
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
Others (Specify):					
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		

With regard to the above information, please explain any special circumstances (custody issues, visitation, adoption, etc.)

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**PAST PSYCHIATRIC HISTORY OF CHILD**

Please list all psychiatric / psychological / speech / hearing / drug or alcohol evaluations or treatments. None Received

Where: \_\_\_\_\_ When: \_\_\_\_\_

Where: \_\_\_\_\_ When: \_\_\_\_\_

Where: \_\_\_\_\_ When: \_\_\_\_\_

Where: \_\_\_\_\_ When: \_\_\_\_\_

Where: \_\_\_\_\_ When: \_\_\_\_\_

Where: \_\_\_\_\_ When: \_\_\_\_\_

**Medications:** Please list all psychiatric, emotional or attentional disorder medications (past & present) by name, dose & approximate dates of treatment:

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If your child has any history of suicide attempts, please explain "when" and "how": No Attempts

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Please review the following list of common behavioral/emotional problems. Check the appropriate box to indicate the extent to which each symptom describes your child.

0 = This does not apply to my child to any significant degree.

1 = This does apply to my child to a moderate degree, at least some of the time.

2 = This clearly applies to my child and often causes significant problems for the child or for those around him/her.

? = I don't know how to answer this question.

0 1 2 ?

Depressed or irritable mood / Lack of interest or motivation / Boredom / Withdrawal from friends

Sleep or appetite/weight changes

Multiple apparently unfounded medical complaints

Self-esteem decreased *from previous level* / Excessive self-blame and guilt

Suicidal behavior or thoughts

Increased tearfulness or rapidly fluctuating moods

Overactivity

Distractibility / Inattentiveness

Fidgeting

Impulsivity

Difficulty following through on instructions

Loses things easily

Shifts from one incomplete activity to another / Focusing difficulties

Argumentative, angry or vindictive behavior

Refuses to comply with reasonable rules

Annoys others deliberately

Swears / Uses obscene language

Stealing / Forgery / Breaking and entering

Running away from home / School truancy

Lying

Fire setting

Homicidal / Dangerous behavior or plans

Cruelty to animals or people

Sexual abuse of others

Physical fights

Arrests / Legal history (If yes, please explain) \_\_\_\_\_

Binge eating

Use of laxatives / Diuretics / Diet pills

Fasting / Strict dieting

Persistent concern with body shape / Weight

Fearful about being separated from you (at school, at night, being left with a sitter)

Fears that harm will come to you or him/her during absences (killed, kidnapped, accident)

Painfully or excessively shy when with unfamiliar people

Preoccupation with cleanliness, excessive handwashing or peculiar orderliness

"Habits" that the child just cannot seem to help

Has unpleasant thoughts that "go around" in the child's head, or being afraid of something they might do

Abnormal motor/movements: jerks, tics of the face, neck, shoulders, mouth, upper or lower body

History of frequent coughing, throat clearing, stuttering, or unusual noises

Soiling or wetting incidents

Substance use, abuse,  
or suspected abuse  
(Circle all that apply)

Alcohol  
Heroin  
Hallucinogens (LSD)  
Others? \_\_\_\_\_

Marijuana  
Opiates  
"Dust" (PCP)

Cocaine  
Tranquilizers  
"Ecstasy"

Are there any other problems that were not addressed in the previous checklist? If yes, please describe below:

\_\_\_\_\_

\_\_\_\_\_

**PAST MEDICAL HISTORY OF CHILD**

Name of Primary Care Physician \_\_\_\_\_

Date of Last Physical Exam \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone # \_\_\_\_\_

As appropriate, please check "Y" (Yes), "N" (No) or "?" (Don't know):

Previous Hospitalizations, Surgery, or Major Illnesses: Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Nature of Medical Problem(s)	Dates of Treatments/Illnesses	Treatment/Condition Outcome
Current Medications: Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Name(s) of Medication(s)	Dosage of Medication(s)	Medication Side Effects
Allergies to Medications: Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Medication(s) Allergic To	Describe Allergic Reaction(s)	
Other Allergies: → Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	(Food/Ragweed/Cats, etc.)		
Immunizations: → Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Are They Current?	If "no", what is still needed?	
Last Hearing Test: →	Date	Results	
Last Vision Test: →	Date	Results	

**CHILD'S PERINATAL AND DEVELOPMENTAL HISTORY**

Number of pregnancies prior to this child: \_\_\_\_\_

Number of live births prior to this child: \_\_\_\_\_

Number of miscarriages/stillbirths prior to this child: \_\_\_\_\_

<b>Pregnancy:</b>	
Age at Time of Child's Conception: _____	
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Full-term pregnancy?
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Medications for the Mother? If "yes", please specify _____
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Bleeding / Spotting?
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Persistent vomiting?
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Eclampsia/pre-eclampsia / High blood pressure / Swelling / Urine protein?
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Drugs or other toxic substances to which Mother was exposed? _____
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Other illnesses? _____
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Maternal weight gain: _____ pounds
<b>Labor and Delivery:</b>	
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Vaginal delivery?
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	C-Section ~ Emergency?
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	C-Section ~ Planned or repeat?
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Forceps used?
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Meconium stain (fetal feces)?
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Breech presentation?
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Fetal bradycardia (slow heart beat)?
<b>Infant's Condition at Birth:</b>	
_____ ? <input type="checkbox"/>	Birth Weight of Child: _____ pounds _____ ounces
_____ ? <input type="checkbox"/>	Apgars: _____ 1 <sup>st</sup> _____ 2 <sup>nd</sup>
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Jaundiced?
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Transfusion(s) required?
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Other after-birth medical problems (difficulty breathing, failing to cry, appearing inactive, etc.)
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Neonatal ICU? – Was baby born with any congenital problems?
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Was the child discharged from the hospital within three (3) days of birth?
<b>First Year of Life: →</b>	
<b>Comments:</b>	
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Bottle-fed?
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Breast-fed? To what age? _____
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Slept well?
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Fretful?
Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>	Bonded well?
How would you describe your baby's temperament? _____	
<b>Milestones: →</b>	
<b>Age and any Comments:</b>	
_____ ? <input type="checkbox"/>	Age at walking unassisted:
_____ ? <input type="checkbox"/>	Age baby spoke first words:
_____ ? <input type="checkbox"/>	Age baby put two or three words together:
_____ ? <input type="checkbox"/>	Age at toilet training:

**CHILD'S ACADEMIC HISTORY**

Please list schools attended, beginning with the most recent:

	<u>Schools</u>	<u>Academic Achievements / Special Services</u>
College:	_____	_____
High School:	_____	_____
Middle School:	_____	_____
Elementary School:	_____	_____

Has your child ever experienced any academic or behavioral difficulties during any time in school? Yes  No   
If yes, please describe the difficulties. \_\_\_\_\_

**CHILD'S SOCIAL HISTORY**

Please list and/or describe:

- (1) Hobbies / Interests \_\_\_\_\_
- (2) Job / Occupation \_\_\_\_\_
- (3) Friends / Social Supports \_\_\_\_\_
- (4) Activities / Sports \_\_\_\_\_

**FAMILY STRESSORS**

Please check all that apply:

- Marital Conflicts
- Parent / Child Conflicts
- Drug / Alcohol by Parents
- Sexual / Physical Abuse
- Physical Illness / Medical Problems
- Recent Deaths
- Frequent Moves
- Financial Problems
- Legal Issues
- Other? \_\_\_\_\_

**THE SPACE BELOW IS FOR YOUR DOCTOR OR THERAPIST TO USE WHEN DISCUSSING WITH YOU ANY OF THE ABOVE ISSUES**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

