Medical and Social History
Children and Adolescents

Child's Name: ________________________________ Information supplied by: ___________________________

Most recent physical exam: _______________________ Results: ____

Major illnesses, allergies and/or surgeries: ____

Hospitalizations (list reasons and dates): ____

Current medications (prescribed or over the counter): ____

List any past psychiatric medications: ____

Relevant family medical or psychiatric history: ____

REVIEW OF YOUR CHILD'S BODILY SYSTEMS:

VISUAL: ☐ No problems ☐ Contacts ☐ Glasses ☐ Other

HEARING: ☐ No problems ☐ Chronic ear infections ☐ Other

RESPIRATORY: ☐ No problems ☐ Asthma ☐ Hay Fever ☐ Congestion ☐ Other

CARDIOVASCULAR: ☐ No problems ☐ High/ low blood pressure ☐ Palpitations ☐ Other

EXCRETORY: ☐ No problems ☐ Urinary infections ☐ Urinary/Bowel Accidents ☐ Other

NEUROLOGICAL: ☐ No problems ☐ Seizures ☐ Headaches/migraines ☐ Memory problems
☐ Head injury/loss of consciousness ☐ Dizziness ☐ Tremors
☐ One-sided body weakness ☐ Other

ENDOCRINE: ☐ No problems ☐ Diabetes ☐ Thyroid dysfunction ☐ Swelling in limbs ☐ Other

MUSCULOSKELETAL: ☐ No problems ☐ Muscle soreness ☐ Joint pain ☐ Restricted motion ☐ Other

REPRODUCTIVE: ☐ No problems ☐ Sex chromosome condition ☐ Ovarian cysts ☐ Penile discharge
☐ HIV + ☐ Other STDs ☐ Sexual worries ☐ Birth control concerns ☐ Other

GASTROINTESTINAL: ☐ No problems ☐ Frequent nausea/vomiting ☐ Large/small appetite
☐ Food intolerance(s) ☐ Frequent constipation ☐ Frequent diarrhea
☐ Abdominal pain ☐ Other

SYMPTOM CHECKLIST: Please check symptom(s) that you have recently observed in your child.

☐ Agitated	☐ Restless	☐ Anxious	☐ Trouble concentrating
☐ Fearful	☐ Worries a lot	☐ Depressed	☐ Repetitive behaviors
☐ Cries often	☐ Doesn't fit in	☐ Confused	☐ Repeating same play or questions
☐ Hopeless	☐ Helpless	☐ Sad	☐ Frequent nightmares
☐ Withdrawn	☐ Desperate	☐ Guilt/Shame	☐ Feeling "out of control"
☐ Suicidal	☐ Overly tired	☐ Distracted	☐ Personality changes
☐ Loses time	☐ Hears voices	☐ See "things"	☐ Self-harm How? ____________
☐ Mood swings	☐ Demanding	☐ Suspicious	☐ Tobacco use (cigarettes)
☐ Overactive	☐ Rapid speech	☐ Combative	☐ Alcohol or drug use
☐ Hostile	☐ Angry	☐ Aggressive	☐ Excessive caffeine use
☐ Passive	☐ Irritable	☐ Racing thoughts	☐ Other: _____________________

SLEEP-REST PATTERNS: (check all that apply) ☐ Awakens early ☐ Wakes up in middle of night

☐ Hard to fall asleep ☐ Sleeps too much ☐ Sleeps too little ☐ Excessive fatigue

☐ Nightmares ☐ Night terrors ☐ Sleep walking _____ # hours of sleep at night

ENERGY LEVEL: ☐ Tires easily ☐ Average energy ☐ High energy

Major events or stressors in child's life and his or her reactions (abuse, illness, death, parental divorce or separation, moves, accomplishments, etc.): ____

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Educational & Social History

Has your child experienced any of the following: (check all that apply)

☐ Attendance problems ☐ Social difficulties ☐ Grade Retentions ☐ Suspensions ☐ Expulsions ☐ Other

Current extracurricular activities: ____

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Separation from parents: ☐ Easier for child than most ☐ Average ☐ Harder for child

Relationship with peers: ☐ Easier for child than most ☐ Average ☐ Harder for child

Social preferences: ☐ Being alone ☐ With peers ☐ With parents ☐ With adults