Medical History

Name: _____ Date: _____

1. Who is the physician who sees your child most often? _____

2. When was the last time your child had a physical check-up? _____

3. Has your child been treated by a physician or hospitalized in the last year? ___ Yes ___ No
   If yes please specify _____

4. Has there been any change in your child's health in the past year? ___ Yes ___ No
   If yes please specify _____

5. Is your child taking any medication (psychiatric, non-psychiatric, over the counter) at the present time? ___ Yes ___ No If yes, please list (continue on back if needed):

Medication	Dosage/Frequency	Name of Prescriber
1.		
2.		
3.		

6. Has your child ever had a history of: (circle all that apply)

High/ Low Blood Pressure	Diabetes	Anemia	Seizures/Epilepsy
Cardiac Problems	Asthma	Tuberculosis	Cancer
Thyroid Problems	Ulcers	Tics	Other _____

7. Does anyone in your family have a history of mental health issues (e.g., depression, anxiety, alcohol, or drug abuse)? ___ Yes ___ No

   If yes, please complete information below:

Family Member	List psychiatric, drug, or alcohol problem

8. Has your child ever been hospitalized for any emotional or psychiatric reason? ___ Yes ___ No
   If yes, please complete information below:

Dates	Name of Hospital	Reason for Hospitalization	Was it Helpful?

9. Has your child ever received psychiatric or psychological treatment before? ___ Yes ___ No
   If yes, please complete information below:

Dates	Name of Professional	Reason for Treatment	Was it Helpful?