Jean M. Monty, PhD.

Psychological Services, LLC

Child/Adolescent History Form

Child's Name: _____ Age: _____ Birthdate: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Cell Phone (if applicable) _____

Name of person accompanying client today: _____ Relationship: _____

Mother's Name: _____ Age: _____ Birthdate: _____

Street Address: _____ Phone: _____

City: _____ State: _____Zip:_____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Remarried ☐Widowed

Name of Mother's Spouse or Partner (if applicable): _____

Father's Name: _____ Age: _____ Birthdate: _____

Street Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Remarried ☐Widowed

Name of Father's Spouse or Partner (if applicable): _____

If parents are divorced/separated, who has legal custody of child?

☐Mother ☐Father ☐Joint ☐Other

Please list siblings, parents, stepparents, etc.

Name:	Relationship:	Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

School Child is Currently Attending: _____ Grade: _____

Name of Teacher(s): _____

Special Programming (IEP, 504 plan, etc):

_____

Past and present academic functioning:

_____

_____

_____

Past and present behavioral concerns with teachers or other students:

_____

_____

_____

_____

Structured Activities: Is your child involved in any clubs, religious organizations, or community groups? _____ If yes, what are they?_____

_____

Activity Level of your child: ☐Inactive ☐Average ☐Overactive

Referred By: _____

Briefly describe the reason for this visit:

_____

_____

_____

_____

Please check the behaviors observed:

☐Depression/sad thoughts	☐Thoughts of suicide	☐Weight loss/gain
☐Sleep Problems	☐Social Withdrawal	☐Irritability
☐Low Energy	☐Memory Problems	☐Running Away
☐Poor Concentration	☐Poor Attention	☐Distractibility
☐Hyperactivity	☐Anxiety/Nerves	☐Panic Attacks
☐Compulsive Behaviors	☐Stealing	☐Racing Thoughts
☐Too Much Energy	☐Anger	☐Aggression/Violence

Has the child/adolescent had mental health treatment before? ☐Yes ☐No
If yes, when and where? _____

Has the child/adolescent had treatment for drug use before? ☐Yes ☐No
If yes, when and where? _____

Has the child/adolescent had any legal involvement? ☐Yes ☐No
If yes, please explain: _____

Has the child/adolescent been involved with the County Department of Human Services?
If yes, please explain:
_____
_____
_____

Does the child/adolescent have any current or ongoing medical problems? ☐Yes ☐No
If yes, please explain: _____
_____

Who is the child/adolescent's primary care physician? _____

What medications does the child/adolescent take? (include non-prescription, herbal meds, & supplements)

Medicine	Dose	Frequency	Who prescribes medication?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What Pharmacy do you use? _____ Phone: _____
Please list any allergies, including medication allergies/sensitivities:
_____
_____

Signature of Parent Completing Form: _____

Witnessed by: _____