



Anita M. Katz, PMHNP

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CHILD/ADOLESCENT HISTORY FORM

Directions: Please fill out as completely as possible. If you are filling this out for your child, please answer the questions from your own perspective. This will help me best meet you and/or your child's needs.

CHILD'S NAME:

DATE:

PARENT NAME:

DATE:

Presenting Problem: (Please check all of your concerns)

<input type="checkbox"/> Fear of hurting yourself	<input type="checkbox"/> Irresponsible	<input type="checkbox"/> Repetitive thoughts
<input type="checkbox"/> Fear of hurting someone else	<input type="checkbox"/> Irritable	<input type="checkbox"/> Repetitive behaviors
<input type="checkbox"/> Self-injury	<input type="checkbox"/> Angry	<input type="checkbox"/> Sees things others do not
<input type="checkbox"/> Fire-setting	<input type="checkbox"/> Sad most of the time	<input type="checkbox"/> Hears things others do not
<input type="checkbox"/> Legal problems	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Difficulty getting to sleep
<input type="checkbox"/> Traumatic event	<input type="checkbox"/> Frequent mood changes	<input type="checkbox"/> Difficulty staying asleep
<input type="checkbox"/> Bed-wetting	<input type="checkbox"/> Feeling anxious/fearful	<input type="checkbox"/> Wanders during night
<input type="checkbox"/> Harmful to animals	<input type="checkbox"/> Tearful	<input type="checkbox"/> Frequent nightmares
<input type="checkbox"/> Argumentative	<input type="checkbox"/> Easily distractible	<input type="checkbox"/> Drug/alcohol use
<input type="checkbox"/> Unable to keep friends	<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Tics/involuntary movements
<input type="checkbox"/> Secretive	<input type="checkbox"/> Impulsive	<input type="checkbox"/> Pre-occupied with sex
<input type="checkbox"/> Lying	<input type="checkbox"/> Memory problems	<input type="checkbox"/> Sexual problems
<input type="checkbox"/> Stealing	<input type="checkbox"/> Lacks confidence	<input type="checkbox"/> Frequent complaints of illness
<input type="checkbox"/> Aggressive toward others	<input type="checkbox"/> Has lost interest in activities/friends	<input type="checkbox"/> Appetite changes
<input type="checkbox"/> Destructive to property	<input type="checkbox"/> Prefers to be alone	<input type="checkbox"/> Recent weight loss or gain
<input type="checkbox"/> Access to weapons	<input type="checkbox"/> Racing thoughts	<input type="checkbox"/> Picky eater
<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Confused a lot	<input type="checkbox"/> Other
<input type="checkbox"/> Helplessness	<input type="checkbox"/> Overly energetic	
<input type="checkbox"/> Blames others	<input type="checkbox"/> Grandiose	



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A: Family History:

WHO DO YOU LIVE WITH?

Mother's name: _____

Yes No

Father's name: _____

Yes No

Step-mother's name: _____

Yes No

Step-father's name: _____

Yes No

Sibling name: _____

Yes No

Sibling name: _____

Yes No

Does religion play a significant role in your family?

Yes No

B. Environmental History: (please check all that apply currently or in the past)

- | | |
|---|--|
| <input type="checkbox"/> Death in the family | <input type="checkbox"/> Financial stress |
| <input type="checkbox"/> Unemployment of self or parent | <input type="checkbox"/> Frequent moves |
| <input type="checkbox"/> Parental illness | <input type="checkbox"/> Emotional abuse |
| <input type="checkbox"/> Crime victim | <input type="checkbox"/> Parental separation or divorce |
| <input type="checkbox"/> Violence at home | <input type="checkbox"/> Violence between family members |
| <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Weapons in the home |
| <input type="checkbox"/> Alcohol abuse self or parent | <input type="checkbox"/> Other (please explain) |
| <input type="checkbox"/> Drug abuse self or parent | |

C: Mental Health History:

Have you ever hurt yourself or attempted suicide? If so, explain:

Have you ever been hospitalized for psychiatric reasons? If so, when and where?



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Are you currently taking any medications for a psychiatric condition? Yes No

Have you ever been in counseling? If so, when and with whom?

D: Alcohol and Drug History:

What, if any, drugs or alcohol are you currently using?

What, if any, drugs or alcohol have you used in the past?

Does your child smoke cigarettes? Yes No How many packs per day?

Have you ever been in alcohol or drug treatment? If so, when and where?

Has any family member had problems with alcohol or drugs? If so, who and when?



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E: Academic History:

- | | | |
|---|--|---|
| <input type="checkbox"/> Victim of bullying/teasing | <input type="checkbox"/> Feel threatened | <input type="checkbox"/> Low grades |
| <input type="checkbox"/> Suspensions/expulsions | <input type="checkbox"/> Special classroom | <input type="checkbox"/> Failing grades |
| <input type="checkbox"/> Underachievement | <input type="checkbox"/> Overachievement | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Social/behavioral problems | <input type="checkbox"/> IEP | <input type="checkbox"/> Skipping/poor attendance |

What grade are you in?

Where do you go to school?

Are you happy with your grades?

Could you do better if you tried?

Is your child currently being home-schooled?

G: Legal History (if applicable):

Have you ever had a legal problem or been involved with the police? If yes, explain.



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H: Medical History:

a) Current medical problems/allergies:

b) Current medications (include dosage):

c) Any past head injuries or serious physical trauma:

d) Nutritional history (please describe any dietary concerns):

Parent Signature

Date

Child/Adolescent Signature (14 years or older)

Date