ANTHROPOS
HEALTH & COUNSELING CENTER
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Child & Adolescent Psychiatric History

Patient Name: _____ Date of birth: _____Age:_____

Mother's name: _____Father's Name: _____

Is this your Biological Child: ( ) Yes ( ) No If Adopted, what age? _____

Referred By: _____Telephone:_____

Who is your child's pediatrician? _____

Address: _____Telephone:_____

Who lives within the child's home?

_____
_____
_____

Are there family members (including biological parents) who live outside of the home? If so, please describe. (If divorced or separated, describe visitation arrangements):

_____
_____
_____

What is your main concern about your child? Describe in your own words:

_____
_____
_____

What kind of services are you seeking for your child?

_____
_____
_____

Symptom Checklist

For the following symptoms, please check those you believe apply to your child and are a significant problem at the present time. Please estimate when these problems were first noted and add any explanation that would be helpful.

- ❑ Often failing to give close attention to details/making careless mistakes_____
- ❑ Often has difficulty sustaining attention in tasks or play_____
- ❑ Often not seeming to listen when spoken to directly ("spacey") _____
- ❑ Trouble following through on instructions or failing to finish schoolwork or chores (not due to oppositional behavior or failure to understand instructions) _____
- ❑ Often has difficulty organizing tasks or activities_____
- ❑ Often avoids or is hesitant to work on tasks that required sustained mental effort (such as schoolwork or homework) _____
- ❑ Often loses necessary things (toys, assignments, pencils, books, etc.) _____
- ❑ Often easily distracted (by sounds, conversations, activity, etc.) _____
- ❑ Often forgetful in daily activities_____
- ❑ Fidgets or squirms in seat_____
- ❑ Difficulty remaining seated_____
- ❑ Inappropriate running or climbing or feeling restless_____
- ❑ Difficulty playing quietly_____
- ❑ Often "on the go" or acts as if "driven by a motor" _____
- ❑ Often talks excessively_____
- ❑ Often blurts out answers to questions before they have been completed_____
- ❑ Has difficulty awaiting turn_____
- ❑ Often interrupts or intrudes on others_____
- ❑ Often loses temper _____
- ❑ Often argues with adults _____
- ❑ Often actively defies or refuses adult requests or rules _____
- ❑ Often deliberately does things that annoy other people_____
- ❑ Often blames others for own mistakes_____
- ❑ Is often touchy or easily annoyed by others_____
- ❑ Is often angry or resentful_____
- ❑ If often spiteful or vindictive _____
- ❑ Depressed or irritable mood most of the day, every day_____
- ❑ Decreased or excessive sleep_____

- ❑ Poor appetite or overeating _____
- ❑ Marked agitation or unusually slowed movement_____
- ❑ Fatigue or unusually slowed movement_____
- ❑ Fatigue or loss of energy_____
- ❑ Decreased pleasure or loss of interest in usual activities_____
- ❑ Poor concentration or difficulty making decisions_____
- ❑ Feelings of worthlessness or excessive inappropriate guilt_____
- ❑ Suicidal thoughts or attempts _____
- ❑ Low self-esteem, negative "self-talk"_____
- ❑ Feelings of hopelessness about the future_____
- ❑ Drug or alcohol use? If yes, please explain? _____
- ❑ Often swears or uses obscene language_____
- ❑ Has stolen without confronting a victim (e.g.) shoplifting_____
- ❑ Often stays out at night, despite parental rules_____
- ❑ Has run away from home overnight at least twice_____
- ❑ Lies often to obtain goods or avoid obligations_____
- ❑ Deliberately sets fires_____
- ❑ Often engages in physically dangerous activities_____
- ❑ Is often truant, skips school_____
- ❑ Has broken into someone's house, car or building_____
- ❑ Has deliberately destroyed other's property_____
- ❑ Has forced someone into sexual activity_____
- ❑ Used a weapon in a fight (e.g. bat, brick, gun, knife) _____
- ❑ Often initiates physical fights_____
- ❑ Has stolen with confrontation (mugging, purse-snatching) _____
- ❑ Physically cruel to people or animals_____
- ❑ Bullies, threatens, or intimidates others_____
- ❑ Unrealistic and persistent worry about possible harm to family or friends_____
- ❑ Unrealistic and persistent worry about future events or that a terrible event will separate the child from a close figure_____
- ❑ Persistent refusal to go to school_____
- ❑ Persistent refusal to sleep alone_____
- ❑ Persistent avoidance of being alone_____
- ❑ Repeated nightmares regarding separation_____
- ❑ Physical pains or illness without a physical cause (headaches, stomachaches) _____
- ❑ Excessive distress in anticipation of separation from attachment figure_____
- ❑ Excessive distress when separated from home or attachment figures_____

- ❑ Unrealistic concern about appropriateness of past behavior_____
- ❑ Unrealistic concern about competence_____
- ❑ Marked self-consciousness_____
- ❑ Excessive need for reassurance_____
- ❑ Marked inability to relax_____
- ❑ Compulsive rituals_____
- ❑ Obsessions (intrusive thoughts) _____
- ❑ Repetitive behavior_____
- ❑ Preoccupation with firearms or knifes_____
- ❑ Odd postures_____
- ❑ Excessive reaction to noise or fails to react to loud noises_____
- ❑ Overreacts to touch_____
- ❑ Motor tics (muscle twitches) _____
- ❑ Vocal tics (e.g. grunts, sniffs, odd noises) _____
- ❑ Loose thinking (e.g. ideas that are hard to follow or don't make sense) _____
- ❑ Bizarre ideas (e.g. odd fascinations, delusions, hallucinations) _____
- ❑ Disoriented, confused, staring, or "spacey" _____
- ❑ Incoherent speech (mumbling, nonsense) _____
- ❑ Hearing voices_____

Medical and Psychiatric History

Check if your child has had any of the following:

Serious illness

❑ No

❑ Yes If yes, please describe:

_____

History of Diabetes:

❑ No

❑ Yes If yes, please describe:

_____

Head injury

❑ No

❑ Yes If yes, please describe:

_____

Surgery

❑ No

❑ Yes If yes, please describe:

_____

Seizures

❑ No

❑ Yes If yes, please describe:

_____

Hospitalizations

❑ No

❑ Yes If yes, please describe:

_____

Asthma or breathing difficulties

❑ No

❑ Yes If yes, please describe:

_____

Tobacco Use

❑ No

❑ Yes If yes, please describe:

_____

Allergies to Medications

❑ No

❑ Yes If yes, please describe:

_____

Trouble with hearing or vision

❑ No

❑ Yes If yes, please describe:

_____

Does your child currently take any medications? If so, list name of medication, dosage, and time taken.

_____

_____

_____

Has your child received any previous psychiatric, other mental health or drug/alcohol treatment?

❑ No

❑ Yes

If yes, who provided the mental health treatment? (Name, address & telephone if available).

_____

_____

_____

When did the treatment occur and what was the outcome?

_____

_____

_____

Has your child ever been treated with anti-depressants or other psychiatric medication?

❑ No

❑ Yes

If yes, please provide name of medication, dosage, frequency, length of time administered.

_____

_____

_____

Family History

Previous psychiatric or emotional illness:

❑ No

❑ Yes If yes, please explain_____

Drug or alcohol difficulties:

❑ No

❑ Yes If yes, please explain_____

Major medical illness:

❑ No

❑ Yes If yes, please explain_____

Birth Development

Was this child a planned pregnancy?

_____

_____

Describe any complications that occurred during the pregnancy:

- ❑ Difficulty in conception_____
- ❑ Toxemia _____
- ❑ Abnormal weight gain_____
- ❑ Measles_____
- ❑ Excessive vomiting_____
- ❑ German measles_____
- ❑ Flu_____
- ❑ Anemia_____
- ❑ High blood pressure_____
- ❑ Other (Rh incompatibility, etc)_____

Did the patient's mother use or ingest any alcohol, legal medication, illegal drugs or cigarettes during pregnancy? If so, please state which, how often and how much.

_____

_____

_____

At this child's birth, what was the mother's age? _____Father's age?_____

Where was this child born (home delivery or hospital)?

_____

_____

Length of pregnancy_____Weeks

Birth weight_____Lbs._____Oz.

Length of labor_____Hours

Apgar Score (if known)_____

Were there any difficulties during birth? If yes, please explain._____

Early Years Development

As best you remember, at what age did this child do the following?

Walked alone: _____ Understood first words:_____

Spoke first words: _____ Spoke in sentences:_____

When was this child toilet trained? Days: _____ Nights:_____

Did bed wetting occur after toilet training?

- ❑ No
- ❑ Yes If yes, until what age? _____

Did soiling occur after toilet training?

- ❑ No
- ❑ Yes If yes, until what age? _____

Were there any medical reasons for bed-wetting or soiling?

- ❑ No
- ❑ Yes If yes, please explain_____

Has this child experienced any of the following problems? If yes, please describe:

Walking difficulty/difficulty with motor coordination or skills

- ❑ No
- ❑ Yes

Sleep problem

- ❑ No
- ❑ Yes

Unclear speech

- ❑ No
- ❑ Yes

Eating Disorder

- ❑ No
- ❑ Yes

Feeding problem

- ❑ No
- ❑ Yes

Difficulty learning to ride a bike

- ❑ No
- ❑ Yes

Underweight problem

- ❑ No
- ❑ Yes

Difficulty learning to skip

- ❑ No
- ❑ Yes

Overweight problem

- ❑ No
- ❑ Yes

Difficulty learning to throw or catch

- ❑ No
- ❑ Yes

Colic

- ❑ No
- ❑ Yes

Separating

- ❑ No
- ❑ Yes If yes, please describe_____

Excessive crying

- ❑ No
- ❑ Yes If yes, please describe_____

Social Development

How does your child relate to others children?

- ❑ Good
- ❑ Fair
- ❑ Poor

Can he or she socially make friends?

- ❑ Yes
- ❑ No If no, please describe_____

Can he or she keep friends?

- ❑ Yes
- ❑ No If no, please describe_____

Can he or she have fights frequently with siblings or peers?

- ❑ Yes If yes, please describe_____
- ❑ No

What role does your child play in group activities?

- ❑ Leader, please describe_____
- ❑ Follower, please describe_____
- ❑ Refuses to cooperate, please describe_____

What hobbies, sports or other activities does your child enjoy?

_____
_____

Describe your child's and your family's support system, including family, friends, church or other supports.

_____
_____
_____

Has your child ever experienced any parental separation, divorces or death of a close family member?

_____
_____
_____

Has your child ever been physically, sexually or emotionally abused or neglected, or has child protective services been involved with your family?

- ❑ No
- ❑ Yes If yes, please describe_____

Have there been any episodes of family violence that your child has witnessed?

- ❑ No
- ❑ Yes If yes, please describe_____

Does your child have access to guns or other weapons?

- ❑ No
- ❑ Yes If yes, please describe_____

If guns or other weapons are present in the home are they in a locked safe or gun cabinet?

- ❑ No
- ❑ Yes

Throughout your child's history, has he or she ever had any suicidal ideation?

- ❑ No
- ❑ Yes If yes, please describe in detail_____

What is your family's religious affiliation, if any? Are there any practices or beliefs that may influence treatment?

_____
_____
_____

Education Development

School name: _____
School district: _____Grade in school_____
Is your child enrolled in any special program? _____

Special Education (specify program) _____
Tutoring (specify area) _____
Counseling _____

- ❑ Speech Therapy_____
- ❑ Physical Therapy_____
- ❑ Occupational Therapy _____
- ❑ Other _____

Is your child receiving any of the above services outside of school? If yes, please specify.

_____
_____

Please identify any school-related problem areas:

- ❑ School subjects (please specify areas) _____
- ❑ Relationship of child with teacher(s) (please specify) _____
- ❑ Relationship of child with peers at school_____
- ❑ Inappropriate placement (for example, child is placed in the wrong grade, child is not receiving appropriate services, etc) _____
- ❑ Child's attitude toward school _____
- ❑ Appropriate conduct in the classroom _____
- ❑ Appropriate conduct in the classroom _____
- ❑ Appropriate conduct after school on the playground, or in unstructured school activities _____

****

Any additional comments or concerns:

_____
_____
_____