Child and Adolescent Outpatient Biopsychosocial History

Blessing Hospital | Hannibal Clinic

Identifying Data

Patient's Name: _____ Date of Birth: _____ Age: _____

Current School & Grade: _____ Race: _____ Sex: _____ Marital Status: _____

Who does the child live with and relationship to child? _____

Address: _____ Phone: _____

If parents are divorced/separated, Name, Address and Phone of other parent: _____

_____

Who has custody of the child and type of custody? _____

Is DCFS involved? _____ Is there a Case Worker? _____

If applicable, Name, Address and Phone of foster parent: _____

_____

Who referred you here? _____ Child's Health Insurance: _____

Physical Appearance: Height: _____ Weight: _____ Build: _____

Chief Complaint

What is the problem or issue that you are here for? _____

How long has this been going on? _____

What do you think happened that caused this problem? _____

Please tell us more about the problem; e.g. how it started, where does it happen, how it has gotten worse, how it affects the child or family, has anyone gotten hurt, etc., what you have tried to make things better, what is your biggest concern?

_____

_____

_____

_____

_____

_____

_____

Psychiatric History

Has the child seen a counselor? _____ If yes, please list below.

Therapist	Clinic	Reason	When	Response

Has the child seen a psychiatrist? _____ If yes, name & location: _____

_____

Has the child ever been hospitalized? _____ Number of hospitalizations? _____

Hospital	When	Reason	Doctor/Therapist

Was past treatment helpful, and how? _____

_____

_____

Were there any problems with past treatment? _____

_____

_____

What medications has the child taken in the past for these problems and were there any problems with these?

_____

_____

Please list all current medications being taken, including over-the-counter medications.

Medication	Reason	Response	How long taken?	Doctor

Medical History

Name of Patient's Doctor: _____ When was the patient last seen? _____

Name of any Specialist Doctor regularly seen: _____

List any current medical problems (e.g. Diabetes, Asthma, Headaches, Seizures): _____

_____

List any surgeries the patient has had: _____

_____

List any allergies the patient has to medications: _____

_____

List any allergies to food or other things: _____

Gender Information

Child's Sex: ☐ Male ☐ Female Is the child sexually active: ☐ Yes ☐ No ☐ Unknown

FEMALE PATIENTS ONLY: Has child started her menstrual cycle? ☐ Yes ☐ No

If yes, at what age? _____ If yes, first day of last menstrual cycle? _____

Any concerns with menstrual cycle? ☐ Yes ☐ No

If yes, please explain? _____

Family History

	Self	Father	Mother	Brother	Sister	Paternal GP	Maternal GP	Aunt	Uncle	Cousins
Nervous, Anxious	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anger Problem	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Violent Behavior	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Suicidal Behavior/Harming Self	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
AD/HD or Behavior Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Learning Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Treatment	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Hospitalization	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Psychiatric Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Is there any other family medical history that the provider should be aware of? ☐ Yes ☐ No

If yes, please explain: _____

Is there any other family history of sudden cardiac death? ☐ Yes ☐ No

Functionality

Special Diet: _____ Regular Physical Activity: _____

Mobility Problems: _____ Sensory Problems: _____

Hobbies/Interests: _____

Groups or Organizations: _____

Religious Belief/Involvement: _____

Which people is the patient closest to? _____

Personal & Social History

Biological Mother's Name: _____ DOB: _____ Education Level: _____

Employment: _____ Medical Problems: _____

Psychiatric History or Drug & Alcohol History: _____

_____

Biological Father's Name: _____ DOB: _____ Education Level: _____

Employment: _____ Medical Problems: _____

Psychiatric History or Drug & Alcohol History: _____

_____

Attitude to problems and treatment: _____

List any step-parents involved: _____

What number of pregnancy was this for the mother? _____ Mother's age at birth: _____ Father's age: _____

Was there any use of drugs, alcohol or cigarettes during the pregnancy? If so, what and how much? _____

_____

Was the child born at term? _____ Birth weight: _____ Length: _____ APGAR: _____

Did the child have any physical problems at birth? _____

_____

Who took care of the child? _____ What kind of baby as the child? _____

Were there any problems in learning to talk and walk (e.g. was it delayed)? _____

_____

Were there problems potty training? _____

Developmental History

If yes, please mark the developmental concerns that you or your child's doctor(s) have about your child:

☐ Hyperactivity ☐ Delay in motor development ☐ Autism/Aspergers/PDD-NOS

☐ Short attention span ☐ Delay in language development ☐ Learning difficulties

List any other developmental or behavioral problems that your child has or may have:

_____

_____

Any significant events or stressors in childhood? _____

_____

Preschool: _____ Problems there? _____

Elementary School: _____ Problems there? _____

_____

How does the child get along with other kids in school? _____

How does the child get along with staff at school? _____

Has the patient received special education services? _____ From what age? _____

Current grades: _____ Past grades: _____ Any history of truancy? _____

Any behavior problems at school? _____

Has there been any abuse (physical, sexual or emotional)? _____

Any DCFS/DFS/DHS involvement? _____

Any current or past legal issues (charges, tickets, probation, etc.)? _____

_____

Has the patient ever been involved in abusing someone else? _____

Has the child had history of cruelty to animals or firesetting? _____

Has the child ever been around domestic violence? _____

Any history of parental incarceration? _____

Does the patient have any children? How many? Guardian? _____

Does anyone in the household (including child) use tobacco products or participate in vaping? ☐ Yes ☐ No

☐ Cigarettes ☐ Smokeless tobacco ☐ Vaping If yes, how many packs per day: _____

Please list any drugs, alcohol or tobacco that the patient has or current uses: _____

_____

_____

Siblings

Name	Age	Medical Problems	Psychiatric Problems	Relationship

Person completing form:_____

Relationship to patient: _____