

# Hampton Mental Health Associates, Inc.

## Child/Adolescent Psychiatric & Medical History

Patient Name		DOB	Age	Gender
Address				
Height	Weight	Date of Last Physical	Last Recorded Blood Pressure /	
School			Grade	
Class arrangement: <input type="checkbox"/> Special <input type="checkbox"/> Regular <input type="checkbox"/> Combination <input type="checkbox"/> Chapter 1 <input type="checkbox"/> Individual educational plan evaluation				
Current living arrangement:				
Parent home		Foster home	Residential facility	
Other				
<b>Caretaker/Relationship</b>			<b>Caretaker/Relationship</b>	
Name			Name	
Address			Address	
Home phone number			Home phone number	
Work phone number			Work phone number	
Parent or legal guardian (person legally authorized to sign for medication and treatment)				
Address and phone number, if different than above				

### Referral Source :

Referred by	
Child's primary physician:	
Address:	
Would you like a copy of the evaluation from this appointment sent to the child's doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you like a copy of the evaluation from this appointment sent to someone else? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, specify to whom	

### Reason for appointment ( Please explain )


## Child/Adolescent Psychiatric & Medical History *(cont'd)*

### Review of Symptoms: (Please describe)


Has your child ever been hospitalized for behavioral or emotional problems?     Yes     No

**If yes: Please explain:**

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Is your child currently on medication?     Yes     No    If yes:

Name of Medication	Dosage	Name of Medication	Dosage

**List any allergies/reactions (plants, animals, medications):**

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### Abuse History ( if any): (Please Explain)


### Medical History: ( If applies, please explain )


### Developmental History: ( Any problem, please explain )


## Child/Adolescent Psychiatric & Medical History (*cont'd*)

<b>Family Household ( Please describe):</b>					
Name	Age	Relationship to Child	Education	Occupation	Health

**Family Stressors: ( Please explain)**


**Marital Information:**

Parents are: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Never married <input type="checkbox"/> Cohabiting (live together)
Who has legal custody: <input type="checkbox"/> Both parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other, specify
Visitation schedule

**Thank you for taking time to complete this questionnaire.**

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**Patient signature (Representative)** **(Relationship)** **Date**

*Comments that you think may be helpful for your provider to know:*