Hampton Mental Health Associates, Inc.

Child/Adolescent Psychiatric & Medical History

Patient Name	DOB	Age	Gender
Address		Email Address	
Height	Weight	Date of Last Physical	Last Recorded Blood Pressure /
School		Grade	

Class arrangement: ☐ Special ☐ Regular ☐ Combination ☐ Chapter 1 ☐ Individual educational plan evaluation

Current living arrangement:

Parent home	Foster home	Residential facility

Other

Caretaker/Relationship	Caretaker/Relationship
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? ☐ Yes ☐ No

Would you like a copy of the evaluation from this appointment sent to someone else? ☐ Yes ☐ 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:

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):

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)*

Family Household (Please describe):

Name	Age	Relationship to Child	Education	Occupation	Health

Family Stressors: (Please explain)

Marital Information:

Parents are:	☐Married	☐Separated	☐Divorced	☐Never married	☐Cohabitating (live together)
Who has legal custody:	☐Both parents	☐Mother	☐Father	☐Other, specify	
Visitation schedule					

Thank you for taking time to complete this questionnaire.

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

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

Revised 07/15