Children's Wisconsin

Patient Name: _____

MRN: _____

CSN: _____

Mental and Behavioral Health
Patient and Family History Form

I. Child's Information

Child's Name: _____ Child's Preferred Name: _____

Date of Birth: ____/____/____ Sex Assigned at Birth: _____ Gender Identity: _____

Name of person completing this form: _____ Relationship: _____

What would be helpful for us to know about your family's religion or culture?

Is the child adopted? ☐ No ☐ Yes, at what age was the child adopted? _____

Does the child know that they are adopted? ☐ No ☐ Yes ☐ N/A

Parent's marital status:

Parent 1: ☐ Married ☐ Domestic Partner ☐ Single ☐ Divorced ☐ Separated ☐ Widow

Parent 2: ☐ Married ☐ Domestic Partner ☐ Single ☐ Divorced ☐ Separated ☐ Widow

II. Developmental History

Was the child born premature? ☐ No ☐ Yes, how many weeks early? _____ Birth Weight: _____

Were there any problems/illnesses during pregnancy or delivery? ☐ No ☐ Yes, explain:

Any use of tobacco, alcohol, or recreational drugs during pregnancy? ☐ No ☐ Yes, list:

Any use of prescription medications during pregnancy? ☐ No ☐ Yes, list:

Write the age at which the child first started to:

Roll Over _____ Sit up _____ Crawl _____ Walk _____

Speak words _____ Speak sentences _____ Toilet train (day) _____ Toilet train (night) _____

Has the child had any of the following?

☐ No ☐ Yes Physical Therapy

☐ No ☐ Yes Occupational Therapy

☐ No ☐ Yes Speech Therapy

☐ No ☐ Yes Child Protective Services

☐ No ☐ Yes Other Community Resources
(i.e. FISS, birth to 3, autism therapy, etc.)

III. Mental Health History

Has your child been seen for any mental health problems before? ☐ No ☐ Yes, list dates and providers (i.e. therapist/psychologist/psychiatrist, psychological testing, hospitalization, drug/alcohol treatment, etc.):

IV. Other Medical History

List all other providers, doctors, or specialists the child sees now:

Name	Reason	Date last seen

Check any of the following tests the child has had and fill in the information:

X	Test	Date of test	Where test was done	Results
	EEG			
	CT Scan or MRI			
	EKG			
	Neuropsychological Testing			Please bring a copy of the report to the first visit

Has your child had any previous surgeries? ☐ No ☐ Yes, list: _____

Has your child had any previous hospitalizations? ☐ No ☐ Yes, list: _____

Are the child's immunizations up to date? ☐ Yes ☐ No, explain: _____

List all medications the child takes now **(please bring pill bottles to the first visit):**

Medication Name	Dose	Times	Reason

V. Family Health History

Please check any biological family members with the following:

	Patient	Mother	Father	Sibling	Comments
Mental Health					
ADHD/ADD					
Alcohol or drug abuse					
Anxiety					
Bipolar/mood swings					
Depression					
Learning problems					
Obsessive-compulsive disorder					
Personality disorder					
Schizophrenia					
Suicidal thoughts or attempts					
Traumatic life event					
Neurological					
Autism Spectrum Disorder					
Headaches or loss of consciousness					
Concussion					
Head injury					
Migraines					
Neurological disorder					
Seizures					
Stroke					
Tics (uncontrolled movement or vocal tic)					
Other Medical					
Allergies to food, medications, environment					
Blood disorder					
Breathing problems					
Cancer					
Diabetes					
Hearing or vision problems					
Heart conditions/problems					
Liver disease					
Low or high blood pressure					
Problems with bed wetting or urination					
Problems with bowel movements or menstruation					
Stomach problems					
Thyroid problems					
Other:					

VI. Social-Emotional Concerns

Which of the following symptoms has the child shown? Please check ***only*** those that apply.

	Yes	Comments
Mood/Emotional Concerns		
Anxious/worries a lot		
Cries easily/often		
Difficulty separating (clingy)		
Frequent changes in mood		
Gets frustrated easily		
Irritable/grouchy		
Keeps to themselves		
Sad often		
Behavioral Concerns		
Aggressive towards animals		
Aggressive/violent towards others		
Destructive to property		
Does the same things over and over		
Hyperactive		
Impulsive (acts without thinking)		
Leaves home or school without permission		
Lies often		
Prematurely independent		
Self-harm or cutting		
Sexual or risky behaviors		
Stealing		
Temper tantrums		
Trouble paying attention		
Other		
Blank staring		
Can't stop thinking about the same thing(s)		
Feels guilty a lot		
Hears things that aren't there		
Mute (won't talk)		
Sees things that aren't there		
Thinks people are against them		
Trauma/Loss		
Abused physically, mentally, or sexually		
Experienced loss/death/separation		
Witnessed violence, verbal, or physical abuse		

Parent/Legal Guardian signature:_____ Date: _____