Health History Form - Child/Teen

Note: Do not stress about getting all the details onto this form. This is used as a starting point to make the discussion more beneficial at your appointment. If you cannot answer a question or feel uncomfortable answering a question, please leave it blank. All questions should be answered from the patient's perspective.

Patient's Legal Name _____ **Birth Date** _____

What should we call you (preferred name)? _____

Pronouns (check or circle all that apply) ☐ she/her/hers ☐ he/him/his ☐ they/them/theirs _____

Curent Gender Identity: ☐ female ☐ male ☐ transwoman ☐ transman ☐ nonbinary _____

Sex Assigned at Birth: ☐ female ☐ male ☐ intersex list other: _____

Name of Person filling out this form and relationship to patient:

What is the main reason or concern that you are seeking care for?

Past Psychiatric History:

Have you ever been treated for the following?

☐ Anxiety	☐ ADHD	☐ Alcohol problems
☐ Panic Attacks	☐ Academic Struggles	☐ Substance Abuse
☐ Depression	☐ OCD	☐ Behavioral aggression
☐ Sleep issues	☐ Friend conflicts	☐ Psychosis
☐ Relationship issues	☐ Eating Disorder	☐ PTSD
☐ Others (list):		

List all current or previous counselors, with approximate start and end dates of care

Name of provider **Dates**

_____

_____

_____

_____

List all previous psychiatrists or APNPs, with approximate start and end dates of care

Name of provider **Dates**

_____

_____

_____

_____

What non-medication treatments have you tried for mental health symptoms?

Have you ever been hospitalized psychiatrically?

☐ Yes ☐ No If yes, when was the last time you were hospitalized: _____

Have you experienced any of the following in the last month?

1)	Feelings of hopelessness or that life is not worth living	☐ Yes	☐ No
2)	Thoughts of hurting yourself	☐ Yes	☐ No
3)	Have a specific plan to hurt yourself	☐ Yes	☐ No
4)	Past suicide attempts ever	☐ Yes	☐ No
5)	Do you self-harm (cutting, burning, etc)?	☐ Yes	☐ No

Past Medical History

What is the name of your primary care provider (PCP) and contact information?

Provider name: _____

Clinic name/address: _____

Clinic phone number: _____

Medical Conditions (Please check or list any medical problems you have experienced.)

☐ Diabetes Type I or II	☐ Cancer / Type:	☐ Heart disease (list):
☐ High blood pressure	☐ High cholesterol	☐ Seizures (list type):
☐ Sleep issues	☐ Thyroid disease	☐ Other:
Additional history:		

Health Habits (check or circle answers)

Tobacco Use:	☐ I smoke everyday	☐ I smoke some days	☐ I am a former smoker	☐ I have never smoked		
On average, how many packs per day currently?	☐ ¼	☐ ½	☐ 1	☐ 1.5	☐ 2	☐ 3
Are you ready to consider quitting?	☐ Yes	☐ No				
Physical Activity: How many days per week of moderate to strenuous exercise? (jogging, running, dancing, swimming, biking, weights) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7						
Alcohol Use: How often do you drink alcohol?	☐ Never	☐ Monthly or less	☐ 2-4 times a month	☐ 2-3 times a week	☐ 4 or more times a week	
How many alcoholic drinks on a day you are drinking?	☐ 1 or 2	☐ 3 or 4	☐ 5 or 6	☐ 7 to 9	☐ 10 or more	
Recreational Drug Use: Do you use recreational drugs?	☐ No ☐ Yes (list specific drugs & frequency):					

Current Medications (Please list and bring the medication bottles with you to your appointment)

Medication	Dosage	Time of day

Previous Medications tried for mental health issues: check or circle yes or no answers)

Medication	Dosage & timing	Year(s) taken	Helpful?	Side Effects?
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Medication Allergies

Medication	Reaction

Social History:

What is your current grade level in school?

Do you have ambitions of what job/career you want?

Is school a struggle for you?

Is there someone in your family you have the most conflicts with?

What do you do to relax or enjoy downtime?

Is there something you would like to get back to doing, that you use to enjoy?

Household members

(List adults first. You can list multiple people on the same line with commas if necessary)

Name	Relationship to patient	Age

Family History (Please place a check mark or X in the box)

Condition	Mother	Father	Brother	Sister
Anxiety				
Depression				
ADHD				
Substance Abuse				
OCD				
Thyroid disease				
High blood pressure				
Other mental health (list):				
Other mental health (list):				

Briefly describe any other concerns not mentioned above and your goals for treatment
(ex: a specific goal on improvement of functioning or enjoying a certain aspect of life again)

fox valley PSYCHIATRY 2024

Return completed form by either:

1) Dropping it off at our office
2) Mailing it back to our office

Address:
Fox Valley Psychiatry
4321 W College Ave, Ste 200
Appleton, WI 54914