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# MEDICAL CHILD BIOGRAPHICAL FORM

**Instructions:** To assist us in helping your child, please fill out this form as fully and openly as possible. All private information is held in strict confidence within legal limits. If certain questions don't apply to the child, leave blank.

1) Information supplied by: _____ Relationship:_____
2) Individual holding legal custody of patient: _____

## Personal History

3) Child's Name: _____
4) Age: _____
5) School Grade Level: _____
6) Gender: ☐ M ☐ F
7) Weight: _____
8) Height: _____
9) Eye color: _____
10) Hair color: _____
11) Race: _____
12) Has the child been involved in previous psychiatric treatment? Yes ☐ No ☐
    If Yes, please describe treatment and results: _____
    _____
13) Why is the child coming for psychiatric treatment at this time _____
    _____
    _____
14) How long has this problem persisted (from 13)?: _____
15) Under what conditions do the problems usually get worse?: _____
    _____
16) Under what conditions are the problems usually improved?: _____
    _____

Continue to next page.

17) Please complete the Health Inventory below:

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area below, if you are not having any difficulties, please check "no Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask your provider.

**Const. (health in general)** ☐ No Problems, or: Lack of energy, unexplained weight gain, unexplained weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer, or other: _____

**Ears, Nose, Mouth & Throat** ☐ No Problems, or: Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness, or other: _____

**C-V (heart & blood vessels)** ☐ No Problems, or: Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs, or other: _____

**Resp. (lungs & breathing)** ☐ No Problems, or: Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray, or other: _____

**GI (stomach & intestines)** ☐ No Problems, or: Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, change in bowel habits, incontinence, or other: _____

**GU (kidney & bladder)** ☐ No Problems, or: Painful urination, frequent urination, urgency prostate problems, bladder problems, impotence, or other: _____

**MS (muscles, bones, joints)** ☐ No Problems, or: Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain, or other: _____

**Integ. (skin, hair & breast)** ☐ No Problems, or: Persistent rash, itching, new or change in skin lesion, hair loss or increase, breast changes, or other: _____

**Neurologic (brain & nerves)** ☐ No Problems, or: Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss, or other: _____

**Psychiatric (mood & thinking)** ☐ No Problems, or: Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions, or other: _____

**Endocrinologic (glands)** ☐ No Problems, or: Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive, or other: _____

**Hematologic (blood/lymph)** ☐ No Problems, or: Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas, or other: _____

**Allergic/Immunologic** ☐ No Problems, or: Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV, or other: _____

**Medication allergies/ Adverse reactions** ☐ No Problems, or: List details: _____

_____

Continued on next page:

| MEDICATIONS List medications you are currently taking |
|---|
| |
| |
| |
| |
| Pharmacy Name _____ Phone _____ |

FAMILY HISTORY Fill in health information about your family.

| Relation | Age | State of Health | Age at Death | Cause of Death | Check (√) if, your blood relatives had any of the following: Disease | Relationship to you |
|---|---|---|---|---|---|---|
| Father | | | | | ☐ Arthritis, Gout | |
| Mother | | | | | ☐ Asthma, Hay Fever | |
| Brothers | | | | | ☐ Cancer | |
| | | | | | ☐ Chemical Dependency | |
| | | | | | ☐ Diabetes | |
| | | | | | ☐ Heart Disease, Strokes | |
| Sisters | | | | | ☐ High Blood Pressure | |
| | | | | | ☐ Kidney Disease | |
| | | | | | ☐ Tuberculosis | |
| | | | | | ☐ Other | |

| HOSPITALIZATIONS Year | Hospital | Reason for Hospitalization and Outcome |
|---|---|---|
| | | |
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| PREGNANCY HISTORY Birth Year | Birth Sex | Complications if any |
|---|---|---|
| | | |
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| | | |

HEALTH HABITS Check (√) which substances used and how much

| | | |
|---|---|---|
| ☐ | Caffeine | |
| ☐ | Tobacco | |
| ☐ | Drugs | |
| | Other | |
| ☐ | | |
| ☐ | | |

Have you ever had a blood transfusion? □ Yes □ No
If yes, please give approximate dates: _____

| SERIOUS ILLNESS/INJURIES | DATE | OUTCOME |
|---|---|---|
| | | |
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OCCUPATIONAL Check (√) if your work exposes you to the following:

| | |
|---|---|
| ☐ | Stress |
| ☐ | Hazardous Substances |
| ☐ | Heavy Lifting |
| ☐ | Other |

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my health care professional or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature Date

_____ _____
Reviewed By Date

**Epworth Sleepiness Scale (ESS)**

18) The ESS is a validated, subjective questionnaire used by health care professionals to screen patient for excessive sleepiness.

Rate your sleepiness for each of the following situations using this scale:
0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

| | |
|---|---|
| ___ Sitting and Reading | ___ Lying down to rest in the afternoon when circumstances permit |
| ___ Watching TV | ___ Sitting and talking to someone |
| ___ Sitting inactive in a public place (e.g., a theater or a meeting | ___ Sitting quietly after a lunch without alcohol |
| ___ As a passenger in a car for an hour without a break | ___ In a car, while stopped for a few minutes in traffic |

**Family History**

19) Mother's age:_____ If deceased, how old was the child when she passed away?:_____
20) Father's age:_____ If deceased, how old was the child when he passed away?:_____
21) If parents are separated or divorced, how old was the child then?: _____
22) Number of brother(s) _____ Their ages _____ _____ _____ _____ _____
23) Number of sister(s) _____ Their ages _____ _____ _____ _____ _____
24) Child number _____ being in a family of _____ children.
25) Is the child adopted or raised with parents other than biological parents?: ☐ Yes ☐ No
26) Briefly describe the child's relationship with brothers and/or sisters:
Biological siblings:_____
_____
_____
Step and/or half siblings:_____
_____
_____
Other:_____
_____
27) What is the family relationship between the child and his/her custodial parents?
Check all that apply:
☐ Single parent mother ☐ Single parent father ☐ Parents unmarried
☐ Parents married, together ☐ Parents divorced ☐ Parents separated
☐ With mother and stepfather ☐ With father and stepmother
☐ Child adopted ☐ Other, describe_____
28) Is there a history or recent occurrence(s) of child abuse to this child? ☐ Yes ☐ No
If Yes, which type(s) of abuse? ☐ Verbal ☐ Physical ☐ Sexual
Comments:_____
_____
29) Parents' occupations: Mother _____ Father_____

30) Briefly describe the style of parenting used in the household: _____
_____

## Family Psychiatric History

31)

| Family Member: | Date/Diagnosis: | Treatment/Results: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## Developmental History

32) Briefly describe any problems in the child's mother's pregnancy and/or childbirth:
_____

33) Please fill in when the following developmental milestones took place:

| Behavior | Age began | Comments |
|---|---|---|
| Walking | _____ | _____ |
| Talking | _____ | _____ |
| Toilet trained | _____ | _____ |

34) List any drugs used by mother or father at time of conception, or by mother during pregnancy:
_____

35) Please rate your opinion of the child's development (compared to others the same age) in the following areas:

| | Below Average | About Average | Above Average |
|---|---|---|---|
| Social | ☐ | ☐ | ☐ |
| Physical | ☐ | ☐ | ☐ |
| Language | ☐ | ☐ | ☐ |
| Intellectual | ☐ | ☐ | ☐ |
| Emotional | ☐ | ☐ | ☐ |

For each type of development that you rated above as *below* average, please describe current areas of concern. Be specific.
_____
_____

36) What report card grades does the child usually receive?: _____
Have these changed lately?: ☐ Yes ☐ No If Yes, how?: _____

37) Briefly describe the child's hobbies and interests:_____
_____

38) Describe how the child is disciplined: _____
_____

39) For what reasons is the child disciplined?_____
_____

## Behaviors of Concern

40) Please check how often the following behaviors occur. Those occurring FREQUENTLY or of special concern may be described on the next page.

| | | | | |
|---|---|---|---|---|
| 1) Loses temper easily | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 2) Argues with adults | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 3) Refuses adults' requests | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 4) Deliberately annoys people | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 5) Blames others for own mistakes | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 6) Easily annoyed by others | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 7) Angry/resentful | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 8) Spiteful/vindictive | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 9) Defiant | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 10) Bullies/teases others | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 11) Initiates fights | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 12) Uses a weapon | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 13) Physically cruel to people | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 14) Physically cruel to animals | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 15) Stealing | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 16) Forced sexual activity | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 17) Intentional arson | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 18) Burglary | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 19) "Cons" other people | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 20) Runs away from home | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 21) Truant at school | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 22) Doesn't pay attention to details | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 23) Several careless mistakes | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 24) Does not listen when spoken to | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 25) Doesn't finish chores/homework | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 26) Difficulty organizing tasks | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 27) Loses things | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 28) Easily distracted | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 29) Forgetful in daily activities | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 30) Fidgety/squirmy | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 31) Difficulty remaining seated | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 32) Runs/climbs around excessively | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 33) Difficulty playing quietly | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 34) Hyperactive | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 35) Difficulty awaiting turn | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 36) Interrupts others | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 37) Problems pronouncing words | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 38) Poor grades in school | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 39) Expelled from school | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 40) Drug abuse (including prescription) | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 41) Alcohol consumption | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 42) Depression | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 43) Shy/avoidant/withdrawn | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 44) Suicidal threats/attempts | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 45) Fatigued | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 46) Anxious/nervous | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 47) Excessive worrying | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 48) Sleep disturbance | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 49) Panic attacks | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 50) Mood shifts | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 51) Caffeine consumption | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |
| 52) Nicotine/Tobacco use | ☐ Never | ☐ Rarely | ☐ Sometimes | ☐ Frequently |

41) For each of the behaviors noted on the previous page as occurring FREQUENTLY, or if it causes significant impairment, write a brief description of how it impacts the child's or other people's lives. Give examples. Use the back of this page as needed.

| Behaviors of Concern | Impact on Child or Others |
|---|---|
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42) Briefly describe the child's ways of expressing the following emotions or behaviors:
ANGER:_____
HAPPINESS:_____
SADNESS:_____
ANXIETY:_____

43) List the child's behaviors that you would like to see change:_____

44) Spiritual/religious orientation: _____

45) Additional information you believe would be helpful:_____

END OF FORM

**Patient Name:**_____ **Date of Birth:** _____

Have you ever been treated for mental health related concerns: ☐ **Yes** ☐ **No**

If yes, please indicate if you are currently taking or have previously taken any of the medications listed below:

| | | | | ***If past, please explain why it was stopped*** |
|---|---|---|---|---|
| *Anafranil (clomipramine)* | ☐ | **current** | ☐ **past** | |
| *Abilify (aripiprazole)* | ☐ | **current** | ☐ **past** | |
| *Ambien (zolpidem)* | ☐ | **current** | ☐ **past** | |
| *Ativan (lorazepam)* | ☐ | **current** | ☐ **past** | |
| *Trintellix (vortioxetine)* | ☐ | **current** | ☐ **past** | |
| *Buspar (buspirone)* | ☐ | **current** | ☐ **past** | |
| *Celexa (citalopram)* | ☐ | **current** | ☐ **past** | |
| *Clozaril (clozapine)* | ☐ | **current** | ☐ **past** | |
| *Cymbalta (duloxetine)* | ☐ | **current** | ☐ **past** | |
| *Depakote (valproic acid)* | ☐ | **current** | ☐ **past** | |
| *Desyrel (trazodone)* | ☐ | **current** | ☐ **past** | |
| *Effexor (venlafaxine)* | ☐ | **current** | ☐ **past** | |
| *Elavil (amitriptyline)* | ☐ | **current** | ☐ **past** | |
| *Emsam (selegiline)* | ☐ | **current** | ☐ **past** | |
| *Eskalith (lithium)* | ☐ | **current** | ☐ **past** | |
| *Fanapt (iloperidone)* | ☐ | **current** | ☐ **past** | |
| *Fetzima (levomilnacipran)* | ☐ | **current** | ☐ **past** | |
| *Geodon (ziprasidone)* | ☐ | **current** | ☐ **past** | |
| *Haldol (haloperidol)* | ☐ | **current** | ☐ **past** | |
| *Inderal (propranolol)* | ☐ | **current** | ☐ **past** | |
| *Invega (paliperidone)* | ☐ | **current** | ☐ **past** | |
| *Klonopin (clonazepam)* | ☐ | **current** | ☐ **past** | |
| *Lamictal (lamotrigine)* | ☐ | **current** | ☐ **past** | |
| *Latuda (lurasidone)* | ☐ | **current** | ☐ **past** | |
| *Lexapro (escitalopram)* | ☐ | **current** | ☐ **past** | |
| *Librium (chlordiazepoxide)* | ☐ | **current** | ☐ **past** | |
| *Lunesta (eszopiclone)* | ☐ | **current** | ☐ **past** | |
| *Luvox (fluvoxamine)* | ☐ | **current** | ☐ **past** | |
| *Mellaril (thioridazine)* | ☐ | **current** | ☐ **past** | |
| *Navane (thiothixene)* | ☐ | **current** | ☐ **past** | |

| | | | | | |
|---|---|---|---|---|---|
| *Neurontin (gabapentin)* | | **current** | | **past** | |
| *Norpramin (desipramine)* | | **current** | | **past** | |
| *Pamelor (nortriptyline)* | | **current** | | **past** | |
| *Paxil (paroxetine)* | | **current** | | **past** | |
| *Pristiq (desvenlafaxine)* | | **current** | | **past** | |
| *Prolixin (fluphenazine)* | | **current** | | **past** | |
| *Prozac (fluoxetine)* | | **current** | | **past** | |
| *Remeron (mirtazapine)* | | **current** | | **past** | |
| *Restoril (temazepam)* | | **current** | | **past** | |
| *Rexulti (brexpiprazole)* | | **current** | | **past** | |
| *Risperdal (risperidone)* | | **current** | | **past** | |
| *Saphris (asenapine)* | | **current** | | **past** | |
| *Serax (oxazepam)* | | **current** | | **past** | |
| *Seroquel (quetiapine)* | | **current** | | **past** | |
| *Sinequan (doxepin)* | | **current** | | **past** | |
| *Tegretol (carbmazepine)* | | **current** | | **past** | |
| *Thorazine (chlorpromazine(* | | **current** | | **past** | |
| *Tofranil (imipramine)* | | **current** | | **past** | |
| *Topamax (topiramate)* | | **current** | | **past** | |
| *Tranxene (clorazepate)* | | **current** | | **past** | |
| *Trilafon (perphenazine)* | | **current** | | **past** | |
| *Trileptal (oxcarbazepine)* | | **current** | | **past** | |
| *Valium (diazepam)* | | **current** | | **past** | |
| *Viibryd (vilazodone)* | | **current** | | **past** | |
| *Wellbutrin (bupropion)* | | **current** | | **past** | |
| *Xanax (alprazolam)* | | **current** | | **past** | |
| *Zoloft (sertraline)* | | **current** | | **past** | |
| *Zyprexa (olanzapine)* | | **current** | | **past** | |

Do you think your current medications are effective: ☐ **Yes** ☐ **No**

If no, please explain:_____

_____

_____