Athans and Associates, Ltd.
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HX - Child and Adolescent History – Ages 0-18

Parents- Please help us provide excellent medical care by completing the information below. This will help us get to know your child and their unique needs.

Personal Information

Patient Name: _____ DOB: ___/___/___ Date: _____

1. Gender: ☐ M ☐ F
2. Race: ☐ White ☐ African Am. ☐ Hispanic ☐ Biracial ☐ Native Am. ☐ Asian ☐ Other

3. Religion: ☐Christian ☐Jewish ☐Muslim ☐Buddhist ☐Other: _____ ☐ None

Biological Family

1. Parents
   a. Father's Age: ____ Occupation: _____
   b. Mother's Age: ____ Occupation: _____
   c. Marital Status: ☐ Married: Years Married ____ ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married Year separated, divorced or widowed: ____ If parents are separated or divorced, who has custody of this child?_____ How often does the other parent see this child? _____
   _____

2. Biological Siblings
   ☐ Brothers: Names and Ages: _____
   ☐ Sisters: Names and Ages: _____

3. If parents divorced, who has legal custody? ☐ Mother ☐ Father ☐ Joint

Current Living Situation

1. Child/Adolescent resides with: ☐ Biological Family ☐ Stepfamily ☐ Adoptive Family ☐ Other

2. Household Members, other than those listed above (Name, age and relationship):
   a. _____
   b. _____
   c. _____

Patient History

1. Academic History:
   a. Current Grade: ____School Name: _____ ☐ Public ☐Private ☐ Home
   b. Classroom Type: ☐ Regular ☐ Learning Disabled ☐ Gifted ☐ Behavior Disorder
   c. IEP/Diagnosed Learning Problems: ☐ None ☐ Reading ☐ Math ☐ Writing
   d. 504 Plan for Attention Deficit Hyperactivity Disorder or other health impaired? ☐ No ☐ Yes

e. Mental Retardation: ☐ No ☐ Yes
f. School Behavior Problems ☐ None ☐ Suspensions ☐ Expulsions ☐ Grade Retention _____
Please describe: _____
g. In-School Activities ☐ None ☐ Clubs ☐ Athletic Teams ☐ Student Gov. ☐ Other: _____
_____

2. Medical History:
a. Prenatal: Pregnancy: ☐ Normal ☐ Complicated Delivery: ☐ Vaginal ☐ C-section
Complications: _____
b. Developmental Milestones: Age: Age:
Walking: _____ Urination trained: _____
Used words: _____ Toilet trained: _____
Sentences: _____
c. Services Received
☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy
Describe: _____
d. Past Medical Problems (illness, injury, trauma, accident, hospitalization, health condition):
i. _____
ii. _____
iii. _____
e. Please list physician's name and address: _____
f. Date of last physical exam: _____ Results: _____
g. Current Medical Issues
i. Allergies: ☐ None ☐ Seasonal ☐ Food ☐ Pets ☐ Peanuts ☐ Latex ☐ Medication ☐ Other:
Describe _____
ii. Current Medical Problems ☐ None ☐ Yes; describe: _____
_____
iii. Current Medications ☐ None ☐ Yes; name and dosage: _____
_____
iv. Current Height: _____ Current Weight: _____
v. Sleep: ☐ Good ☐ Poor, explain: _____
vi. Appetite: ☐ Good ☐ Poor, explain: _____

3. Mental Health History:
a. Outpatient Psychotherapy ☐ No ☐ Yes; Problem(s), where and when treated: _____
_____
_____
i. How did treatment terminate? _____
b. Inpatient Hospitalization: ☐ No ☐ Yes; Problem(s), where and when treated: _____
_____
c. Residential Treatment: ☐ No ☐ Yes; Problem(s), where and when treated: _____
_____
d. Physical/Sexual Abuse History
i. Physical Abuse: ☐ No ☐ Yes ☐ Unknown ii. Sexual Abuse: ☐ No ☐ Yes ☐ Unknown
If yes; comment _____
DCFS Involvement: ☐ No ☐ Yes; describe: _____
e. Family Mental Health History
i. Father/Father's Family History of problems ☐ None ☐ Yes ☐ Unknown
If yes, describe: _____
ii. Mother/Mother's Family History of problems ☐ None ☐ Yes ☐ Unknown

If yes, describe: _____

iii. Siblings History of problems ☐ None ☐ Yes ☐ Unknown

If yes, describe: _____

4. Substance Use History:

a. ☐ None ☐ Alcohol ☐ Illegal Drugs ☐ Prescription Drugs ☐ Cigarettes ☐ Unknown

If yes, substance(s) used: _____

b. Treatment for Substance Abuse: ☐ No ☐Yes; When and where _____

_____

5. Psychological/ Social Stressors:

a. Child Stressors: ☐ None ☐ Yes; please identify: _____

b. Family Stressors: ☐ None ☐ Yes; please identify: _____

6. Arrest History ☐No ☐Yes; Number of Arrests: _____ Charges Filed: _____

Social Relations and Activities

1. Friends

a. Approximate Number of Friends: _____ Best Friend ☐ No ☐Yes

i. Boyfriend/Girlfriend ☐ No ☐ Yes: Length of Relationship: _____

b. Activities enjoyed with friends: _____

2. Hobbies ☐ No ☐ Yes; please identify: _____

3. Extracurricular Activities ☐ Volunteer Activities ☐ Sports Teams ☐ Clubs ☐ Other _____

Purpose of this Evaluation

1. Who suggested your child be evaluated/treated? _____

2. Please describe the problems/issues that are affecting your child and your family: _____

_____

_____

How long has this been occurring? _____

3. What do you consider to be your child's best qualities or strengths? _____

_____

_____

4. Is there any additional information you would like to share with us? _____

_____

_____

5. Are there specific goals you would like to achieve? _____

_____

_____

_____ _____ _____

Parent's Signature Date Provider's Signature