David S. Deuser M.D. & Associates

ADOLESCENT TREATMENT HISTORY

Patient's Name_____ DOB:_____Age:_____

Address:_____

Phone #:_____School Attending_____Grade_____

Parents Name	Age Birthplace	Education	Occupation
Mother			
Father			
Stepmother			
Stepfather			
Date Married	Parents Status ( ) Married	( ) Widowed ( ) Separated	( ) Other
Date Separated or Divorced		Date Remarried	
Other Family Members	Age	Grade/Occupation	Present Whereabouts

Who is your Family Physician or Pediatrician?_____

When was your child's last physical examination?_____

Has your child been seen by a Psychiatrist, Psychologist, or at a clinic? (If yes explain)_____

_____

Who suggested that you contact our office for help?_____

Patient Name:_____ DOB:_____

ADOLESCENT TREATMENT HISTORY

What is the problem your child needs help with?_____
_____

Does your child have friends?_____
_____

Does your child get along with other children?_____
_____

Does your child have any special interests, hobbies, clubs, ext?_____
_____

What pleases you most about your child?_____
_____

What concerns or worries you most about your child?_____
_____

Is your child aware of the problems or concerns?_____

Is your child worried? (explain)_____
_____

What questions would you like me to try and answer for you?_____
_____

What changes would you like to see?_____
_____

PAST MEDICAL HISTORY

Does your child have any physical handicap, disabilities, or deformities?(If yes explain.)_____
_____

Has your child had any major injuries, illness, or operations?

ILLNESS	INJURY	AGE/YEAR	HOSPITAL? HOW LONG?	FEVER? HOW LONG?	PHYSICIAN

Does your child have any allergies?_____
_____

Patient Name:_____ DOB:_____

ADOLESCENT TREATMENT HISTORY

PAST PSYCHIATRIC, LEGAL HISTORY

Has there been any past psychiatric, psychological, social work or counseling service done for your child, yourself,, or other members of tor family?

FAMILY MEMBER	NAME OF THERAPIST OR PHYSICIAN	PROVIDERS ADDRESS	DATES

Is there history of alcoholism drug abuse by child, parents, or siblings?_____
_____

Has anything happened, in the family or elsewhere, that may have affected the child's feeling or behavior(illness, deaths, moves, family problems,ext?)_____
_____

How does your child get along with other family members? What problems and with whom?____
_____

DEVELOPMENTAL HISTORY OF YOUR CHILD

Was the pregnancy normal?_____ Length of Pregnancy:_____

If overdue, how late?_____ If early, how early?_____

How long was the active labor?_____

What type of delivery?___natural____caesarean

Was the child born_____head first_____feet first

What was the child's birth weight?_____

Was the child a twin?_____

was a blood transfusion done?_____

Patient Name:_____ DOB:_____

ADOLESCENT TREATMENT HISTORY

IN FIRST TWO WEEKS OF LIFE DID CHILD	IN LATER INFANCY, DID THE CHILD HAVE
Appear yellow?	Vomiting?
Have blue lips?	Diarrhea?
Have difficulty breathing?	Sleeping problems?
Convulsions or twitching?	Constipation?
Feeding difficulties?	Colic?
Show irritability?	Unusual weight gain?
Respond slowly?	Unusual weight loss?

Has your child had any difficulty with the following?

CATEGORY	YES	NO	AGE	HOW LONG DID THE PROBLEM LAST
Head banging				
Thumb sucking				
Teeth grinding				
Fascinations				
Eyes				
Toilet				
Lived away from home				
Sleeping				
Short attention span				
Eating				
Fire setting				
Temper tantrums				
Weight				
Teeth				
Daddy's girl				
Mama's boy				
Sexual difficulties				
Masturbation				

Patient Name:_____ DOB:_____

CATEGORY	YES	NO	AGE	HOW LONG DID THE PROBLEM LAST
Ears				
Early social contacts				
Separation difficulties				
Pre-school experience				
Fears				
Torturing animals				
Legal difficulties				
In or out of School suspensions				

If you checked "yes" to any of the questions above please describe the problem(s)_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Name:_____ DOB:_____

ADOLESCENT TREATMENT HISTORY

School History

Name of school_____Grade_____

Location of school_____

Has your child ever been suspended or expelled from school, if "yes" please explain_____
_____

Has your child had any learning problems, if "yes" please explain_____
_____

What is your child's attitude toward school?_____

PRESENT LIVING ARRANGEMENTS

Living with which of the following [check one]

____Own mother and father

____Own mother and stepfather

____Own father and stepmother

____Adoptive mother and no father

____Other. If other what is relationship to child
_____

____Own mother and no father

____Own father and no mother

____Adoptive mother and father

____Foster parent(s)

____Institutional or residential setting

Does child share a room with anyone else, if "yes" with whom?_____

If "no", how long has child had his/her own room?_____

How long has the child lived in the present residence?_____

How many times has the child's residence changed?_____

ADOLESCENT TREATMENT HISTORY

Health of family members:(Diabetes, Heart Disease, Mental Illness, Suicide, Mental Hospitalization,etc)

INDIVIDUAL	MAJOR ILLNESS	WHEN	HOW LONG HOSPITALIZED	AGE	DECEASED WHEN?	AGE	CAUSE
FATHER							
MOTHER							
FT'S FATHER							
FT'S MOTHER							
MT'S FATHER							
MT'S MOTHER							

Is there any mental retardation in the child's family, if "yes" explain._____
_____

Is there any history of seizure disorder in the child's family, if "yes" explain._____
_____

Developmental Milestones

Please state the age when the child first performed the following:

Loco-motor

Sat up, unassisted_____

Walked alone_____

Speech

Used 10-12 word labels(i.e."Bye-bye Mama")_____

Made simple sentences(i.e. "Me go, Want Milk")_____

Used the word "NO"_____

Toilet Trained

Age when started_____

Describe, problems, child's reaction_____

Bed wetting :From_____To:_____

Soiling:From_____To:_____

Patient Name:_____ DOB:_____

ADOLESCNET TREATMENT HISTORY

Weaning

Age when started_____

Describe problems, child's reaction_____

_____

Separation Difficulties

School Entry(Age)_____

Child's Reaction_____

Discovery of Sexual Differences

Age_____

Menarche (periods);Age and child's reaction to any problems_____

_____

Legal Guardians Name:_____

Date of Birth_____

Social Security#_____

Employer_____

Work phone number_____

Relationship to child_____

Legal Guardians Signature_____

Patient Name:_____ DOB:_____