JUNE PEDIATRIC CONSULTING

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Pediatric Behavioral and Mental Health Services

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YOUTH PERSONAL HISTORY

Today's Date: _____/_____/_____

Client Information

Client's Last Name	First	Middle	
Birth Date / /	Age	Sex	Phone No.

Please fill out below if you are completing this form on behalf of the client:

Name	Relationship to Client	Does the Client live with you? Y / N
Home Phone No. ( )	Cell Phone No. ( )	Work Phone No. ( )

Primary reason(s) for seeking services: _____

_____

Briefly discuss how the above symptoms impair the client's ability to function effectively: _____

_____

_____

Home Information

Home Address: _____

Main language spoken at home: ☐ English ☐ Spanish ☐ Other: _____

Please list all adults and children who live at home with the client:

Name	Age	Relationship to Client

Please explain if there any living arrangements, custody issues, parental divorce/disagreements, or other concerns:

_____

_____

_____

General Medical/Physical Health History

Name of Primary Care Provider/Clinic	Phone No. ( )
Address:	Date of last physical exam

Up to date with immunizations? ☐ Yes ☐ No ☐ Unsure

Please list any allergies (including medications and foods): _____

_____

Dates and reasons for prior hospitalizations: _____

_____

Dates and reasons for prior surgeries: _____

_____

Any complications with the client's birth? ☐ Yes ☐ No ☐ Unsure

If yes, please explain: _____

Use of alcohol, drugs, or tobacco by client's mother during pregnancy? ☐ Yes ☐ No ☐ Unsure

If yes, please list substance and frequency if known: _____

Does the client have any health concerns?

Concern	Current	In the past
Genetic disorder	☐	☐
Significant weight loss or gain	☐	☐
Seizures	☐	☐
Tics, tremors, usual movements	☐	☐
Headaches	☐	☐
Head/brain injury (concussion, trauma, loss of consciousness, etc.)	☐	☐
Vision or hearing problem	☐	☐
Heart problem (arrhythmias, murmurs, chest pain, palpitations, fainting, etc.)	☐	☐
Respiratory problem (asthma, wheezing, chronic cough, TB, etc.)	☐	☐
GI problem (vomiting, reflux/heartburn, stomach pain, diarrhea, constipation, etc.)	☐	☐
Kidney/bladder/genital problems	☐	☐
Skin problems (rashes, excessive itching or dryness, change in skin color, etc.)	☐	☐
Anemia or blood disorders	☐	☐
Endocrine or hormone disorders (diabetes, thyroid conditions, etc.)	☐	☐
Bone, joint, or muscle problems	☐	☐
Health concern not listed above, please explain:	☐	☐

If you selected any of the boxes above, please describe:

What medicines, vitamins, and nutrition supplements are currently used?

Medicine	Dose (how many mg and how often)	Reason

Development, Behavioral, and Mental Health History

Current education/school and grade: _____

Any academic difficulties or discipline problems at school? ☐ Yes ☐ No

If yes, please explain: _____

_____

Does the client have any of the following supports?

☐ 504 plan ☐ IEP ☐ District-based services ☐ Special education teacher ☐ Small classroom

☐ Counseling ☐ Learning/resource room ☐ Speech therapy ☐ Physical/occupation therapy ☐ Other:

Please describe any concerns about the client's development: _____

_____

_____

Has the client ever experienced any traumatic event, including but not limited to: death of someone close, natural disaster, divorce of parents/caregivers, or witnessing violence? ☐ Yes ☐ No ☐ Unsure

If yes, please explain: _____

_____

_____

Is there a personal history of neglect, physical, emotional, or sexual abuse? ☐ Yes ☐ No ☐ Unsure

If yes, please explain: _____

_____

_____

Has the client ever been diagnosed with a psychiatric or neurological disorder? ☐ Yes ☐ No ☐ Unsure

If so, what were they diagnosed with? ☐ Autism ☐ ADD/ADHD ☐ Anxiety disorder

☐ Development Delays ☐ Depression ☐ Other: _____

Who made the diagnosis and when? _____

Is the client currently involved in counseling? ☐ Yes ☐ No

If yes, please list the therapist and their contact information: _____

_____

Were medicines to treat mental health or behavior problems used in the past?

Medicine	Dose	Start Date	End Date	Response

Please list any clubs, activities, or sports the client is involved with: _____

_____

Please list the client's strengths. What are his/her interests? What things are going well? _____

_____

_____

How does the client cope with anger and frustration? _____

_____

Are there weapons kept in the client's home? ☐ Yes ☐ No ☐ Unsure

Any use of recreational drugs or illegal substances? ☐ Yes ☐ No ☐ Unsure

If yes, please specify: _____

What concerns do you have right now?

Concern	
Motor skills (walking, running, using hands, writing, using utensils, etc.)	☐
Communication skills (using words/gestures, expressing wants/needs, understanding others)	☐
Social skills (making friends, playing with others, showing interest in others)	☐
Thinking, learning, and memory	☐
Short attention span	☐
Hyperactivity (constantly moving, restless, active, etc.)	☐
Anxiety (worrying, shy, fearful, problems with separation)	☐
Repetitive thoughts/behaviors (does things over and over, gets "stuck", etc.)	☐
Repetitive motor mannerisms (rocks, flaps hands, paces, etc.)	☐
Mood swings/irritability	☐
Tantrums	☐
Aggression towards self or others (hits or bites, bangs head, etc.)	☐
Sensory issues (sensitive to sounds, touch, smell, etc.)	☐
Self-care (feeding self, getting dressed, helping around the house, etc.)	☐
Sleep problems (trouble falling asleep, wakes frequently, etc.)	☐
Safety concerns (runs away, poor awareness of surroundings, climbs furniture, etc.)	☐
Other behavior concerns, please explain:	☐

Please make notes about any concerns selected above:

Family History

Please indicate if someone in the client's biological family has any of the following disorders:

Disorder		Relationship
ADHD	☐	
Anxiety	☐	
Alcoholism or substance addiction	☐	
Autism spectrum disorder	☐	
Visual or hearing impairment in childhood	☐	
Bipolar disorder	☐	
Cerebral palsy	☐	
Depression	☐	
Diabetes	☐	
Heart rhythm problems or murmurs	☐	
Heart attack at young age (under age 40)	☐	
Intellectual disability	☐	
Learning disability	☐	
Migraine headaches	☐	
Schizophrenia	☐	
Seizures	☐	
Speech delay or disorder	☐	
Sudden, unexpected death not due to accident	☐	
Suicidal attempt or completion	☐	
Tremor or other problem with moving muscles	☐	
Other condition not listed above, please explain:	☐	

Please make notes about any selected above:

Consent for Evaluation:

I certify that the above facts are true to the best of my knowledge. I request to be evaluated and consent to receive treatment by June Pediatric Consulting, PLLC.

Client Signature: _____ **Date:**_____

Client Printed Name: _____

The authorization below is given on the client's behalf because the client is a minor or unable to sign.

Name: _____ **Relationship to Client:**_____

Signature: _____ **Date:**_____

***For patients aged 13-18, please have both the adolescent and parent/guardian sign**