Capital Mental Health
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240-483-0862 (fax)

For Parents: Child's Life History Questionnaire

Please complete this form prior to your first appointment, and submit via email to admin@capitalmentalhealth.com or to the fax number above.

Today's date: _____

Child's name: _____

Child's date of birth: _____ Age: _____

Identified Gender: M F Other Choose not to answer

Preferred Pronouns: _____

Address: _____

_____

Phone: _____

Parent 1 name: _____ Age: _____

Parent 2 name: _____ Age: _____

Name of person completing this form: _____

Relationship to child: _____

Referred by: _____

(1) Please state the reason that you are seeking psychiatric evaluation for your child. What is the problem(s)? When did the problem(s) begin? What has been done to try to alleviate the problem(s)?

(2) Has your child been previously evaluated by a psychiatrist or other mental health professional? If so, please describe:

(a) Date of evaluation: _____
Name of clinician: _____
Outcome of evaluation (diagnosis, recommendation for treatment or for further evaluation, etc.): _____
_____
_____

(b) Date of evaluation: _____
Name of clinician: _____
Outcome of evaluation (diagnosis, recommendation for treatment or for further evaluation, etc.): _____
_____
_____

(3) Has your child received any previous treatment, including therapy, counseling, or medication, for the treatment of emotional, behavioral, or learning problems? If so, please describe:

(a) Dates of therapy/counseling: from _____ to _____
Name of therapist: _____
Was treatment helpful? Please describe its effects: _____
_____
_____

(b) Dates of therapy/counseling: from _____ to _____
Name of therapist: _____
Was treatment helpful? Please describe its effects: _____
_____
_____

(c) Dates of prescribed medication: from _____ to _____
Name of physician: _____
Name of medication: _____
Was treatment helpful? Please describe its effects: _____
_____
_____

(d) Dates of prescribed medication: from _____ to _____
Name of physician: _____
Name of medication: _____
Was treatment helpful? Please describe its effects: _____
_____
_____

(4) Has your child ever been hospitalized for psychiatric treatment? If so, please describe:

(a) Dates of hospitalization: from _____ to _____
Name of hospital: _____
Reason for hospitalization: _____
_____ Was hospitalization helpful? Please describe its effects:
_____
_____ _____

(b) Dates of hospitalization: from _____ to _____
Name of hospital: _____
Reason for hospitalization: _____
_____ Was hospitalization helpful? Please describe its effects: _____
_____
_____

**** Please bring to the first appointment the names, addresses, and phone numbers of the individuals, clinics, or hospitals where previous treatment has taken place.**

Please add any additional comments about previous treatments: _____
_____
_____
_____

(5) Medical History

Please indicate whether your child has suffered from any of the following medical problems:

__Head injury (concussion, loss of consciousness) __Seizure
__Recurrent headaches
__Recurrent stomachaches or digestive problems __Asthma

__Diabetes __Anemia

__Kidney disease __Liver disease __Heart disease __Hearing impairment
__Glaucoma __Thyroid disease __Other

Other medical problems: _____
_____
_____
_____

Please describe any of the above: _____
_____
_____
_____
_____
_____

Has your child ever been hospitalized for medical illness?
Dates: from _____ to _____
Hospital: _____
Reason for hospitalization: _____
_____
_____

Does your child have any allergies? Please describe: _____
_____

Does your child currently take medication? Please include over-the-counter medications such as cold or allergy preparations, as well as any herbal or naturopathic medicines):

Name of medicine: _____ Dosage: _____
Taken since: _____
Reason for medicine: _____
_____

Name of medicine: _____ Dosage: _____
Taken since: _____
Reason for medicine: _____
_____

If your child is a biological female, have they started to have menstrual periods? If yes, when?
_____

Date of child's last physical examination: _____
Name of child's primary care physician: _____

Address: _____

Phone: _____

(6) Developmental History

Was this a planned pregnancy? Y N

Did the biological mother have any medical problems during the pregnancy? Y N
Did the biological mother take any medications during the pregnancy? Y N
Did the biological mother use alcohol, tobacco, or drugs during the pregnancy? Y N

If yes to any of the above, please describe: _____
_____

At how many weeks gestation did the delivery occur? _____ Birth weight: _____
APGAR Scores (if known): _____

Were there any medical complications associated with delivery (e.g., premature delivery, caesarean section, forceps delivery, emergency delivery, meconium, etc.)? Y N

If yes, please describe:_____
_____

Did your child have any medical problems as a newborn (e.g., low birth weight, jaundice, breathing problems, neurological problems, admission to the NICU, etc.)? Y N
If yes, please describe: _____
_____
_____

Describe your child's temperament as an infant: _____
_____
_____
_____

Were there delays in your child's motor development (age at which he/she rolled over, sat up, stood, walked, ran, etc.)? Y N

If yes, please describe: _____
_____
_____

Were there delays in your child's speech and language development (age at which he/she babbled, spoke first word, used two-word combinations, etc.)? Y N

If yes, please describe: _____
_____

At what age was your child toilet trained? Bladder _____ Bowel _____

Since being toilet trained, has you child had problems with:

Wetting at night	Y N	If yes, until what age? _____
Wetting during the day	Y N	If yes, until what age? _____
Soiling at night	Y N	If yes, until what age? _____
Soiling during the day	Y N	If yes, until what age? _____

As an infant, toddler, and preschooler, did your child:

Have any problems with sleep? Y N If yes, please describe:
_____
_____

Have any problems with eating? Y N If yes, please describe:
_____
_____

Have any unusual or particularly severe fears? Y N If yes, please describe:
_____
_____

Have particular difficulty separating from caregivers? Y N
If yes, please describe: _____
_____

Have more frequent or severe temper tantrums than other children? Y N

If yes, please describe: _____
_____

Appear more restless or hyperactive than other children? Y N
If yes, please describe: _____
_____

How well does your child get along with other children? _____
_____
_____

What are your child's favorite activities, hobbies, and pastimes? _____
_____
_____

What are your child's greatest strengths? _____
_____
_____
_____

(7) Academic History

Current grade: _____
Current school: _____
Address: _____
_____

Phone: _____

Has your child ever been left back in school? Y N
If yes, when and why was he/she left back? _____
_____

Has your child ever skipped a grade? Y N
If yes, when and why did he/she skip? _____
_____

Has your child ever been in special education classes? Y N
If yes, when and what type of classroom setting? _____
_____

What grades does your child earn in school? _____
_____

Have teachers or others ever suggested that your child might have a learning disability? Y N If yes, please describe: _____
_____

Has your child ever received educational or cognitive testing? Y N
If yes, when and where did this testing occur? What were the results?
_____
_____

**** Please bring any testing reports to the first appointment.**

Has a teacher ever commented that your child displays emotional or behavioral difficulties in school? Y N
If yes, when and what were you told? _____
_____

Please describe any other concerns you have about your child's academic progress:
_____
_____
_____

(8) Home Environment

Child's parents are (please check appropriate response):

__Married and living together
__Unmarried and living together
__Unmarried, not living together
__Divorced
__Separated
__Mother deceased
__Father deceased
__Both parents deceased
__Unknown

If parents are divorced, date divorced: _____

If child is adopted, age at adoption: _____
Does child know of adoption? Y N

Members living in household:

Parent #1 name: _____ Age: _____ Sex: M F
Parent #2 name: _____ Age: _____ Sex: M F
Sibling's name: _____ Age: _____ Sex: M F
Sibling's name: _____ Age: _____ Sex: M F
Sibling's name: _____ Age: _____ Sex: M F
Sibling's name: _____ Age: _____ Sex: M F

Others:

Name: _____ Age:_____ Relationship: _____
Name: _____ Age:_____ Relationship: _____
Name: _____ Age:_____ Relationship: _____

Please list any siblings not living in the household:

Sibling's name: _____ Age: _____ Sex: M F
Sibling's name: _____ Age: _____ Sex: M F
Sibling's name: _____ Age: _____ Sex: M F

Do any family or household members currently suffer from significant physical health problems? Y N If yes, please describe: _____
_____
_____

Do any family members or household members currently suffer from significant mental or emotional health problems? Y N If yes, please describe: _____
_____

Parent 1 highest educational attainment: _____
Father's occupation: _____

Parent 2 highest educational attainment: _____
Mother's occupation: _____

Are there currently or have there been any significant marital problems?
Y N If yes, please describe: _____
_____
_____

Are there currently any significant stressors affecting your family life?
Y N If yes, please describe: _____
_____
_____

(9) Family History (if known)

Has your child's biological father or have any of his family members had any of the following problems?

	Father	Father's Father	Father's Mother	Father's Siblings	Other Family
Depression					
Anxiety					
Bipolar Disorder					
Obsessive/Compulsive Disorder					
Schizophrenia					
Alcohol abuse					
Drug abuse					
Learning problems					
Hyperactivity					
Psychiatric hospitalization					
Mental retardation					
Autism-related disorder					
Criminal behavior					
Psychiatric Hospitalization					
Suicide attempt(s) or completed suicide					
* If you know the medication used for a condition listed above, please note med name, if it was helpful, or if there was an adverse effect / side effect.					

Has your child's biological mother or have any of her family members had any of the following problems?

	Mother	Mother's Father	Mother's Mother	Mother's Siblings	Other Family
Depression					
Anxiety					
Bipolar Disorder					
Obsessive/Compulsive Disorder					
Schizophrenia					
Alcohol abuse					
Drug abuse					
Learning problems					
Attention Deficit / Hyperactivity Disorder					
Psychiatric hospitalization					
Mental retardation					
Autism-related disorder					
Criminal behavior					
Psychiatric Hospitalizations					
Suicide attempt(s) or completed suicide					
* If you know the medication used for a condition listed above, please note med name, if it was helpful, or if there was an adverse effect / side effect.					

(10) Please provide any additional information that you believe might be helpful in understanding the problem your child is having: _____

_____
_____
_____
_____
_____
_____
_____
_____

Addendum for adolescents:

a. Has your child exhibited any self-destructive behavior? Have you any concerns that your child has hurt himself/herself? _____
_____
_____

b. Describe any concerns you have about your child's weight or eating habits:
_____
_____
_____

c. Are you concerned about depression in your child? Please describe:
_____
_____
_____

d. Do you suspect that your child may be using alcohol or drugs? Please describe: _____
_____
_____

e. How does your child relate to other teenagers? How do you feel about his/her peer group? _____
_____

f. How does your child spend his/her free time? _____
_____
_____

g. With whom does your child share personal information?_____
_____
_____

h. Has your child been sexually active, pregnant, or responsible for a pregnancy? _____
_____

i. Do you have concerns relating to your child's sexual orientation or gender identity?_____
_____

j. Has your child ever been involved with the police or juvenile justice authorities? _____
_____