ARBOR MENTAL HEALTH CENTER
CHILD/ADOLESCENT PERSONAL HISTORY

Ages 0 – 17 Years

IMPORTANT

If a question does not apply, write N/A. If you do not know the answer, write DO NOT KNOW.
NOTE: The information you provide is confidential and protected by law.

Client Name_____ Age _____ DOB_____ Ethnicity_____
Address _____ City _____ State _____ Zip _____

Writing Hand: ☐ Right ☐ Left ☐ Ambidextrous Primary Language Spoken:_____

Who referred you for the evaluation: _____Reason: _____
Have you ever had neuropsychological or psychological testing completed before:☐ Yes ☐No
If yes, by whom?_____ When?_____ Why?_____

Mental Status Exam

Orientation: *Year_____ Month_____ Day_____ Time _____ Current Location_____*

Registration: ***(****name three objects and ask patient to repeat them back)* ***Apple, Table, Penny***
☐ *Apple* ☐ *Table* ☐ *Penny*

Appearance:☐ *Casual dress, normal grooming and hygiene* ☐ *Other:*_____

Attitude: ☐ *Calm and cooperative* ☐ *Other:*_____

Behavior: ☐ *No unusual movements or psychomotor changes* ☐ *Other:*_____

Speech: ☐ *Normal* ☐ *Pressured* ☐ *Tangential* ☐ *Circumstantial*

Affect: ☐*Normal range* ☐ *Depressed* ☐ *Constricted* ☐*Flat* ☐ *Labile* ☐*Blunted* ☐ *Reactive* ☐ *Tearful*

Mood: ☐*Euthymic* ☐ *Irritable* ☐ *Elevated* ☐ *Anxious* ☐*Depressed*

Thought Process and Content:
*Goal-directed and logical or disorganized?*_____
Delusions, phobias, or obsessions/compulsions present? ☐ *Yes* ☐ *No*
Is the person suicidal and/or homicidal? ☐ *Yes* ☐ *No* *(if yes, please explain)*_____

_____

Perception: *Any display of hallucination or delusion during the interview?* ☐ *Yes* ☐*No*

Insight/Judgement: ☐*Good* ☐*Fair* ☐*Poor*

Recall: *(have patient recall and name the three objects from earlier)*
☐ *Apple* ☐ *Table* ☐*Penny*

History of Presenting Problem

Why are you being seen for this neuropsychological evaluation (e.g. I had a stroke, I got into a car accident and sustained a head injury, Family members say I have memory problems, ect.)?_____

Approximate date problem(s) began:_____ Are they: ☐ Getting Better ☐ Getting Worse ☐ Staying the Same

Current Neuropsychological Problems

Please check all categories that apply (examples for each are provided to assist in selection)

☐ ***ATTENTION***

Frequently missing details, making careless errors	Difficulty paying attention for long periods of time
Easily distracted	Difficulty following directions

OTHER

☐ ***PROCESSING SPEED***

Difficulty thinking quickly	Feeling as though most people talk to fast
Taking longer to complete tasks than before	Frequently asking people to repeat themselves (not related to hearing difficulties)

OTHER

☐ ***LEARNING & MEMORY***

Difficulty remembering recent events, names, faces, the date, ect	Difficulty learning and remembering new information
Loss of long-term memories	Forgetting to take medication

OTHER

☐ ***EXECUTIVE FUNCTIONING***

Acting before thinking	Difficulty problem solving, or making bad decision
Difficulty following multi-step direction	Difficulty planning and organizing

OTHER

☐ ***NONVERBAL/VISUAL SPATIAL SKILLS***

Getting lost in familiar locations	Problems driving
Inappropriate use of objects (e.g. remote as a hat)	Right-left or directional disorientation

OTHER

☐ ***SPEECH & LANGUAGE***

The feeling that a word is on the tip of your tongue	Mislabeling items (ex. Clock vs. watch)
Reduced speech volume	Difficulty understanding others or following conversations

OTHER

☐ **MOTOR/COORDINATION**

Difficulty buttoning a shirt	Difficulty opening medicine bottles
Difficulty with walking or balance/ recent falls	Shakiness/Tremor

OTHER

☐ ***SENSORY***

Reduced senses of smell	Tingling sensation
Loss of feeling in part of your body	Difficulty perceiving your bodies location in space

OTHER

☐ ***PHYSICAL PROBLEMS***

Frequent headaches	Bowel or Bladder Incontinence
Dizziness, nausea, vomiting	Shortness of Breath
Sleep Disturbance / Weight Change	Pain

OTHER

☐ ***MOOD & BEHAVIOR***

Increased irritability	Hallucinations (visual, auditory, or olfactory)
Increased sadness / crying for unknown reasons	Increase nervousness, suspiciousness, ect.
Thoughts of harming yourself or taking your life	Discomfort in social situations

OTHER

☐ ***RECENT LIFE STRESSORS***

Change in job	Change in marital status
Death of a loved one	Financial or legal problems
Moved to a new location	Taking care of aging or ill loved one

OTHER

Please rate your overall stress level: ☐Very Low ☐Low ☐Average ☐High ☐Very High Greatest source of stress:

Current Clinical Concerns

Please check all categories that apply

Behavior Concerns:

- ___ Self- injury behavior
- ___ Physical aggression
- ___ Verbal aggression
- ___ Lying/ stealing
- ___ Trouble making friends
- ___ Trouble keeping friends
- ___ Head banging
- ___ Hair twirling/ pulling
- ___ Alcohol/ drug use
- ___ Struggles socializing
- ___ Withdrawn
- ___ Clingy
- ___ Child is a loner
- ___ Tearful
- ___ Perfectionist
- ___ Refusal to attend school
- ___ Rage
- ___ Talks back
- ___ Swears at people, things, situations
- ___ Nightmare
- ___ Sexually acting out
- ___ Other _____

Emotional Distress:

- ___ Depression/ Sadness
- ___ Anger
- ___ Moodiness
- ___ Anxiety
- ___ Suicidal/ homicidal
- ___ Psychotic- like symptoms
- ___ Death
- ___ Parent divorce
- ___ Other _____

Functional Concerns:

- ___ Poor Hygiene
- ___ Problems with mobility
- ___ Problems with hearing
- ___ Problems with speech
- ___ Recognition of danger
- ___ Money management
- ___ Safety problems
- ___ Employment
- ___ High or low energy
- ___ Irresponsible
- ___ Physical pain/ injury
- ___ Impulse control
- ___ Social relationships
- ___ Sleep problems
- ___ Eating problems
- ___ Sensory problems
- ___ Poor grades
- ___ Memory problems
- ___ Learning problems
- ___ Cognitive problems
- ___ Problems with play
- ___ Concentration problems
- ___ Unmotivated
- ___ Lack of coordination
- ___ Fine motor skills
- ___ Feeding aversion
- ___ Difficulty chewing/ swallowing

☐ OTHER:

Activities of Daily Living

Does the child drive: Yes☐ No ☐

Who does the cooking at home: Self ☐ Another Person ☐

Can child manage their own finances: Yes ☐ No ☐

Can child manage their own medication: Yes ☐ No☐

Is child employed: Yes☐ No☐ If yes, where and for how long:_____

Education

Name of School: _____ What type of grades: A B C D F

School Clubs/Sports: _____ Current Grade: _____

Favorite Subject: _____ Least Favorite Subject: _____

Do you have academic difficulties: Yes☐ No☐ If yes, please explain: _____

Have you ever repeated a grade: Yes☐ No☐ If yes, what grade(s): _____

Have you been diagnosed with a learning disabilities: Yes☐ No☐ If yes, please explain: _____

Is an IEP in place at school: Yes ☐ No ☐ If yes, please explain: _____

Has the child ever been suspended or expelled from school: Yes ☐ No☐ If yes, please explain: _____

_____

Does your child attend daycare or before/ after school care? If so, where: _____ Frequency: _____

How long have they been in attendance? _____

Medical History:

Name of physician: _____ Clinic: _____ Last seen on: _____

Reason for visit: _____

Known allergies: _____

☐ NONE Please list your currently prescribed medications: (if you need more room, please attach a piece of paper with all medications)

MEDICATION	DOSE	FREQUENCY	REASON FOR TAKING

Please check the box to indicate any problems that have been identified as having and note (estimate) the year of diagnosis

NEUROLOGIC	DATE	ENDOCRINE	DATE
☐ Brain Injury		☐ Diabetes	
☐ Brain Aneurysm		☐ Hypoglycemia	
☐ Migraines		☐ Hypothyroidism	
☐ Movement Disorder		☐ Hyperthyroidism (ie. Graves)	
☐ Brain or Spinal Tumor		☐ Parathyroid Disorder	
☐ Stroke		☐ Adrenal Gland Disorder (ie. Addisons)	
☐ Seizures		☐ Kidney Disorder	
☐ Dementia		☐ Cushing's Syndrome	
☐ Narcolepsy		☐ Low Testosterone	
☐ Sleep Disorder		☐ Menopause	
CARDIOVASCULAR	**DATE**	**EAR, NOSE, & THROAT**	**DATE**
☐ High Blood Pressure		☐ Dizziness (ie. vertigo, BPPV)	
☐ High Cholesterol		☐ Chronic Ear Infections	
☐ Heart Disease		☐ Swallowing Disorder	
☐ Arteriosclerosis		☐ Macular Degeneration	
☐ Blood Disease (ie. anemia)		☐ Cataracts or Glaucoma	
GENITAL-URINARY/GASTRO-INTESTIONAL	**DATE**	**MUSCULAR-SKELETAL**	**DATE**
☐ Bowel or Bladder Incontinence		☐ Amputation	
☐ Colon Disease (ie. Crohn's, IBS)		☐ Arthritis	
☐ Regular Urinary Tract Infections		☐ Degenerative Joint Disease	
☐ Gastroesophageal Reflux Disease		☐ Osteoporosis	
☐ Pancreatitis		☐ Fibromyalgia	
☐ Liver Disease (ie. hepatitis)		☐ Chronic Fatigue Syndrome	
ONCOLOGY	**DATE**	**GENETIC**	**DATE**
☐ Type & Site of cancer: _____ _____		☐ Type (ie. Fragile X, Down Syndrome, Mitochondrial Disease) _____	
MENTAL HEALTH	**DATE**	**OTHER**	**DATE**
☐ Anxiety Disorder			
☐ Mood Disorder (ie. Depression, Bipolar)			
☐ Psychotic Disorder (ie. Schizophrenia)			
☐ Substance Use/Abuse Disorder			

Has the child had any blood work or imaging (ie. CT, MRI, X-Ray) done in the past year: Yes☐ No☐

If yes, what was done & when: _____

Eating:

___ No Problems
___ Drooling ___ Food falls from mouth ___ Texture sensitivity ___ Gags ___Eats limited type of food
___ Increase/ Decrease in appetite- Since: _____ Obsessed with food- Since: _____
___ Weight gain/ loss- Since: _____ How much: _____

Current Sleep:

___ Duration in hours ___Requires naps ___Midnight awakening ___Early awakening ___ Difficulty falling asleep
___ Nightmares ___ Frequency: ___ per week ___ Content: _____
Was the child attached to any inanimate object (i.e. blanket, teddy bear, etc.)? ___ Yes ___No
If yes, what object? _____ From age: _____ to _____

Family Medical History

☐ UNKOWN Please check any diagnosis that your family members (blood relatives only) have

Medical Condition	Mother	Father	Mother's Mother	Mother's Father	Father's Father	Father's Mother	Sibling	Other
Dementia								
Seizures								
Movement Disorder (ie. Parkinson's)								
Multiple Sclerosis								
Migraines								
Stroke								
Diabetes								
Hypertension								
Cancer								
Hyper/Hypothyroidism								
Genetic Disorder								
Learning Disorder								
ADHD								
Mental Retardation								
Other: _____								

Mental Health History

Has the child EVER received treatment for depression, anxiety, or any other emotional difficulty: (Please check all that may apply)

☐ Never received mental health treatment of any kind
☐ Outpatient counseling
☐ Inpatient psychiatric hospitalization
☐ Pharmacological treatment (anti-depressants, anti-anxiety medications, ect)
☐ Other:

Is the child CURRENTLY receiving treatment for any of the above conditions/difficulties: Yes ☐ No ☐

Please list any therapists, psychologists, or psychiatrist's that the child has or is seeing

Provider Name	Dates Seen	Reason for visits

Please list any psychiatric hospitalizations that the child has had

Hospital	Dates	Reason for Stay

Has the child ever thought about committing suicide: Yes☐ No☐ If yes, when: _____
Has the child ever discussed a plan: Yes ☐ No ☐
Has your child ever attempted to commit suicide: Yes ☐ No ☐ If yes, when: _____ how: _____

Significant Trauma: (Include age at time of incident, nature of trauma and any legal details) ☐ Other:

__ Injured in an accident: _____
__ Physical abuse (Child was the ___ Victim ___) Perpetrator: _____
__ Sexual abuse (Child was the ___ Victim ___) Perpetrator: _____
__ Emotional abuse (Child was the ___ Victim ___) Perpetrator: _____
__ Neglect (please explain) _____
__ Removed from home ___ Placed in foster care ___ Placed with other family
__ Parent or others removed from the home If yes, please explain: _____
__ Coping with divorce If yes, please explain: _____
__ Head injuries or loss of consciousness If yes, how many times: _____ Last time occurred: _____
__ Seizures If yes, frequency: _____ Length of time they last: _____ Occurring for how long: _____
__ Pregnancy & delivery complications If yes, explain: _____
__ Alcohol or drug use during pregnancy If yes, explain: _____
__ Delays in meeting developmental milestones on time If yes, please explain: _____

☐ Unknown

Family Mental Health History

Diagnosis	Mother	Father	Mother's Mother	Mother's Father	Father's Mother	Father's Father	Sibling	Other
Attention Difficulties								
Learning Difficulties								
School Problems								
Behavior Problems								
Depression								
Anxiety								
PTSD								
Drug/ Alcohol Abuse								
Hallucinations/ Delusions								
Bipolar								
Eating Disorder								
Autism								
Attempted Suicide/Suicide								

Social Background

*Mother's Name:*_____ Ethnicity: _____
Address: _____ Phone: _____
Employer: _____ Occupation: _____ Work Phone: _____
Parenting Style: __Firm __Loose __Laid-back __Yells __Avoids __Fun __Hovers __Harsh __Talks too much __Conflictual __Calm

Father's Name _____ Ethnicity: _____
Address: _____ Phone: _____
Employer: _____ Occupation: _____ Work Phone: _____
Parenting Style: __Firm __Loose __Laid-back __Yells __Avoids __Fun __Hovers __Harsh __Talks too much __Conflictual __Calm

Stepmother's Name _____ Ethnicity: _____
Address: _____ Phone: _____
Employer: _____ Occupation: _____ Work Phone: _____
Parenting Style: __Firm __Loose __Laid-back __Yells __Avoids __Fun __Hovers __Harsh __Talks too much __Conflictual __Calm

Stepfather's Name _____ Ethnicity: _____
Address: _____ Phone: _____
Employer: _____ Occupation: _____ Work Phone: _____
Parenting Style: __Firm __Loose __Laid-back __Yells __Avoids __Fun __Hovers __Harsh __Talks too much __Conflictual __Calm

Any special family circumstances you would like us to be aware of?

_____
_____

Where was the child born: _____ Where was the child raised: _____ Who raised the child: _____
Has the child ever lived with anyone other than parents (foster care, relatives, etc.)? Yes ☐ No☐
Please Explain: _____
Was this during the first three years of life? Yes☐ No ☐
Please Explain: _____

Name of Sibling	Living in the home Yes	No	Date of Birth	Full/Half/Step	Quality of Quality of Relationship		
	☐	☐			☐ Good	☐ Fair	☐ Poor
	☐	☐			☐ Good	☐ Fair	☐ Poor
	☐	☐			☐ Good	☐ Fair	☐ Poor
	☐	☐			☐ Good	☐ Fair	☐ Poor
	☐	☐			☐ Good	☐ Fair	☐ Poor

Others Living in Household	Date of Birth	Relationship to Child	Quality of Relationship		
			☐ Good	☐ Fair	☐ Poor
			☐ Good	☐ Fair	☐ Poor
			☐ Good	☐ Fair	☐ Poor
			☐ Good	☐ Fair	☐ Poor

Other Important People in the Child's Life	Date of Birth	Relationship to Child	Quality of Relationship		
			☐ Good	☐ Fair	☐ Poor
			☐ Good	☐ Fair	☐ Poor
			☐ Good	☐ Fair	☐ Poor
			☐ Good	☐ Fair	☐ Poor

Exposure/Use of Substances

Please complete to the best of your knowledge

Caffeine Use: Never used ☐ Currently uses ☐ Type & how much: _____ Quit ☐ when: _____
Tobacco Use: Never used ☐ Currently uses ☐ Type & how much: _____ Quit ☐ when: _____
Alcohol Use: Never used ☐ Currently uses ☐ Type & how much: _____ Quit ☐ when: _____
Drug use: Never used ☐ Currently uses ☐ Type & how much: _____ Quit ☐ when: _____
(including prescription abuse)
Please provide any additional details on usage: _____
_____
_____

Legal History

Does the child have any legal history (prior court cases, arrests, probation, ect.): Yes☐ No☐
If yes, please explain: _____

Name of Probation officer: _____ Phone: _____

Is the child under court ordered guardianship: Yes ☐ No ☐
If yes, list guardian name(s): _____ Phone: _____

Additional Information

Any additional comments, questions, or requests you would like to bring to the doctor's attention: _____
_____
_____

_____ _____ _____ _____
Signature of Parent/Guardian Date Signature of Doctor Date