Alarus healthcare

Patient Name: _____

Child / Adolescent History Form

Please provide the following to help us understand your child's living situation:

Child's Last Name _____ First _____ MI _____

Date of Birth _____ Age _____ Gender _____ Language _____

Lives with _____ Relationship _____

Primary Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Parent Name _____ Age _____

Address ☐ same as above, or _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Marital Status (circle) single married separated divorced widowed cohabitating other

Parent has (circle all) primary custody joint custody primary placement shared placement other

Other members of household (list) _____

Parent Name _____ Age _____

Address ☐ same as above, or _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Marital Status (circle) single married separated divorced widowed cohabitating other

Parent has (circle all) primary custody joint custody primary placement shared placement other

Other members of household (list) _____

Siblings Names	Sex	Age	Type (Bio, Step, Half, etc)	Living Situation

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Patient Name:_____

Instructions: Please provide the following information to assist us in best helping your child and family.

Child's Name _____ **Today's Date** _____

Name of Parent/Guardian completing form: _____

What problem is your child having that concerns you?

_____

_____

_____

_____

When did the problem start?

_____

Has the child ever received mental health treatment? If so, where, when and by whom? _____

_____

Has the child ever taken medication for emotional or behavioral problems? If so, what, when and by whom? _____

_____

What do you see as your child's strengths? _____

_____

In the past month, what has been your child's biggest success or accomplishment? _____

_____

Who does your child look to for help and support? _____

_____

What are your family's strengths? _____

_____

Who do you as a parent rely on for support and assistance? _____

_____

Is your child receiving any other special help or therapies? (List)

_____

_____

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Patient Name: _____

Medical History

Please answer the following questions regarding your pregnancy and delivery with this child:

Pregnancy ☐ Mother was healthy

☐ Mother had health problems: _____

☐ Mother smoked ☐ Used alcohol ☐ Used drugs

☐ Violence toward mother during pregnancy

Delivery ☐ Full-term ☐ Premature at ____ months ☐ Adopted at _____ of age

☐ List any medical complications _____

☐ List any congenital problems _____

☐ Extended hospital stay for ☐ Infant and/or ☐ Mother

Has your child had a history of medical problems? (Describe)

_____

_____

_____

Have there been significant hospitalizations, operations, procedures or injuries? (Describe)

_____

_____

Are there current medical problems or concerns? (Describe)

_____

_____

_____

_____

Is the child currently taking medication? (List medication, dosage, reason for medication and prescribing physician)

_____

_____

_____

_____

Name of Child's Primary Care Physician/Pediatrician _____

Address: _____ Phone: _____

Has your child seen the Primary Care Physician/Pediatrician within the past year? ☐ Yes ☐ No