ADVANCED BEHAVIORAL CENTERS OF DUPAGE

Terrace Executive Center
1 S. 376 Summit Ave., Court D, Unit 5B
Oakbrook Terrace, IL 60181
Physicians: (630) 629-6550
FAX: (630) 629-6558

Hinsdale Professional Office Center
501 W. Ogden Ave., Suite 1
Hinsdale, IL 60521
Therapists: (630) 986-0599
Fax: (630) 986-1477

Child/Adolescent History Form

Name of school attended: _____

Current grade level: _____

Address of School: _____

City: _____ Zip: _____

Telephone: Day _____ Eve _____

Relationship to Patient: Mother ☐ Father ☐ Other (specify) _____

Problems you are concerned about (list briefly): _____

_____

Parents:

Who has legal custody? _____

Name of biological Mother _____

Do both parents agree with treatment and evaluation of your child?(circle one) Yes ◯ No ◯

Address, if different than above. _____

Occupation: _____

Work ph. _____ Home ph. _____

Name of biological Father: _____

Address, if different than above. _____

Occupation: _____

Work ph. _____ Home ph. _____

Name and location of stepmother if applicable) _____

_____

Name and location of stepfather (if applicable) _____

_____

MEDICAL HISTORY

Was the pregnancy for this child planned? (circle one) Yes No

Were there any problems during the pregnancy or birth? (circle one) Yes No

If yes, describe:

Was this child born full term, after 9 months of pregnancy? (circle one) Yes No

If born early, how early?_____months

What was his/her weight at birth? _____

Did he/she have severe colic or feeding problems the first 3 months? (Circle one) Yes No

If yes, explain:

Do you feel your child developed normally the first two years of life? (Circle one) Yes No

How old was this child when he/she did the following?

Crawled: _____ Walked: _____ Said first word: _____

Spoke in two or three word phrases:_____ Toilet Trained: Bowel_____

Toilet trained: bladder_____ Remained clean and dry all night: _____

Attended Daycare:_____ Attended Preschool or School the first time: _____

When was your child's last physical exam? _____

Does he/she have any current or past medical problems? (Circle one) Yes No

If yes, describe: _____

Has he/she had any injuries such as broken bones, head injuries? (Circle one) Yes No

If yes, describe:

Does your child have any problems with vision or hearing? (circle one) Yes No

When was your child's last hearing and vision screening? _____

Has he/she had any surgeries? (circle one) Yes No

If yes, describe:

_____

Does he/she have any allergies (including allergies to medications)? (circle one) Yes No

If yes, what?

_____

_____

Please list any current medications, vitamins, or herbal remedies that your child takes:

PAST PSYCHIATRIC HISTORY

Please describe any past mental health treatment that your child has received:

SUBSTANCE ABUSE HISTORY

Please describe any known substances that your child is using or has used in the past:

_____

FAMILY HISTORY

What is the child/family's religion(s)? _____

What is the child/family's ethnicity? _____

Has any biological relative of this child been diagnosed with any psychiatric disorder, including: Anxiety Disorder, Depression, Bipolar Disorder, Manic Depression, Attention Deficit/Hyperactivity Disorder (ADHD/ADD), Obsessive Compulsive Disorder, Schizophrenia, Developmentally Disabled or Mentally Retarded, Alzheimer's Disease or Dementia, Motor Tics, Tremors, or Tourette's Disorder?

Please list relation to the child, i.e., father, mother, aunt etc. and the disorder:

_____

Has any biological relative of this child committed suicide? _____

Has any biological relative of this child had a problem with alcohol or drug abuse?

_____

Has any biological relative of this child had a learning disability?

_____

Is there any family history of neurological disorders or other medical conditions?

_____

Is there any history of cardiovascular problems in the family?

_____

SOCIAL HISTORY

FAMILY MEMBER	NAME	DATE OF BIRTH	OCCUPATION	HIGHEST LEVEL OF EDUCATION COMPLETED
Mother				
Father				
Step-Mother (if applicable)				
Step-Father (if-applicable)				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				

Who currently resides in the household with your child _____

_____

Has he/she ever been treated or evaluated by a psychiatrist, psychologist, or therapist? Yes ◯ No ◯

If yes, list names, dates treated:

Name:_____Date Treated: _____

Name:_____Date Treated: _____

Does he/she smoke cigarettes, drink alcohol, or use any drugs? ◯ Yes ◯ No ◯ Unsure

If unsure or yes, describe: _____

_____

Has he/she had any involvement with the police or the courts? ◯ Yes ◯ No

If yes, describe: _____

_____

_____

SCHOOL INFORMATION

School patient is attending:

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

Previous Schools Attended:

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

Use the space below if you would like to clarify any of your answers above: