AUGUSTA PSYCHOLOGICAL ASSOCIATES

CHILD FAMILY PSYCHIATRY - PATIENT HISTORY

Name	**Date of Birth**
Referred By: Address	
Reasons for Treatment	
Previous Treatment (including therapists' names, dates of treatment, medication and any hospitalizations)	
Primary Doctor's Name and Address	
Current Health Problems	
Current Medications (including doses and frequency)	
Allergies (including what reaction the patient had)	
Difficulties during Pregnancy or Delivery in patient or mother	
Cigarette, Alcohol, or Drug Use by Mother during Pregnancy	
Major Medical Problems since Birth (including illnesses, injuries, head trauma)	
Does the patient have a history of structural heart defect or arrhythmia, palpitations, chest pain, fainting episodes, high blood pressure, or seizures?	Yes ___ No ___

Please continue questionnaire on reverse side.

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Developmental Milestones:

Age of crawling: Age of walking:

Age of talking in phrases: Age of toilet-training:

Child's Brothers and Sisters (including names and ages)

Names of All People Living in the Home

If Parents are Separated, Age of Child When Parents Separated:

Frequency of contact with other parent: Custody (Circle One): Joint Mother Father

Any Known Abuse in the Family (physical, sexual, or emotional)

School Child is Currently Attending **Grade**

Family History

Has anyone in your family ever suffered from:	(Check Box) Yes	No	If yes, please explain and indicate which family member:
ADHD	[ ]	[ ]	______
Depression	[ ]	[ ]	______
Anxiety	[ ]	[ ]	______
Hallucinations	[ ]	[ ]	______
Suicide	[ ]	[ ]	______
Manic depression	[ ]	[ ]	______
(bipolar disorder)	[ ]	[ ]	______
Diabetes mellitus	[ ]	[ ]	______
Heart Disease	[ ]	[ ]	______
Sudden Death	[ ]	[ ]	______
High Blood Pressure	[ ]	[ ]	______
Cancer	[ ]	[ ]	______
Seizures	[ ]	[ ]	______

Other: ______________________________

Completed by: ______________________________ **Relationship to Patient:** ______________

Reviewed by: ______________________________ Date/Time ______________________