The Jones Center for Children's Therapy and Assessment
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ADOLESCENT (AGES 12 – 17/18) PATIENT HISTORY

Name: _____ **Ethnicity:** _____ **DOB:** _____ **Age:** _____

Dear Parent,
To help establish your adolescent with our practice, please provide us with his/her complete medical and mental health history. At the end of this document, there is a short form we would like your son or daughter to complete independently, if he/she is willing. Thank you and we look forward to working with you and your adolescent!

In your own words, please describe why you are seeking services for your adolescent: _____
_____
_____
_____

Were you referred by an outside source, such as a pediatrician? Who? _____

Family Members/Others Residing in Your Home	**Age**	**Relationship to Adolescent**

How does this adolescent get along with other family members in the home? Defiant? Antagonistic? Alliances? Other problems? _____
_____

Important Others Residing Outside Your Home	**Age**	**Relationship to Adolescent**

How does this adolescent get along with family members/important people residing outside the home? _____
_____
_____

Parents'/Legal Guardians' Marital Status: Married Divorced Separated Never Married Other: _____
If separated or divorced, how old was your adolescent at the time of occurrence? _____ How did he/she adapt to the change? _____
_____
_____

Maternal Family Psychiatric History (If so, who?)
Depression/sadness _____
Suicidal ideation/attempt _____
Anxiety/excessive worry _____
Panic attacks _____

Paternal Family Psychiatric History (If so, who?)
Depression/sadness _____
Suicidal ideation/attempt _____
Anxiety/excessive worry _____
Panic attacks _____

Posttraumatic Stress Disorder _____
Bipolar Disorder_____
Obsessive-compulsive tendencies_____
Schizophrenia_____
Attention problems/ADHD_____
Learning problems _____
Autism Spectrum Disorder _____
Alcohol/drug abuse_____
Problems with the law_____
Seizures_____
Other_____

Posttraumatic Stress Disorder _____
Bipolar Disorder_____
Obsessive-compulsive tendencies_____
Schizophrenia_____
Attention problems/ADHD_____
Learning problems _____
Autism Spectrum Disorder _____
Alcohol/drug abuse_____
Problems with the law_____
Seizures_____
Other_____

Does this child have a sibling(s) or half-sibling(s) who suffers any of the aforementioned psychological issues/disorders? Y or N If yes, who and what? _____

_____

Birth History

Was the pregnancy planned? Y or N Desired? Y or N Prenatal care received? Y or N Is he/she adopted? Y or N
Complications during pregnancy? Y or N If Yes, please explain:_____

_____

Nausea:_____ Vomiting:_____ Swelling:_____ Headaches/migraines:_____ Diabetes:_____
Other illnesses:_____ Bed rest:_____Why?_____How long?_____
Tobacco use: _____ How much:_____ Alcohol use:_____ How much:_____
Prescription drug use: _____What:_____ Illicit drug use:_____What:_____
Length of pregnancy:_____ Was labor induced? Y or N If Yes, why? _____

_____

How was he/she delivered? (i.e., vaginally, with forceps, with vacuum assistance, etc.)_____

_____

Weight at birth: _____ Complications during delivery? Y or N If Yes, please explain:_____

_____

Did this child require admission into the neonatal intensive care unit (NICU)? Y or N If Yes, how long and why? _____

_____

This child has met majority of his/her developmental milestones in a timely manner: _____Yes _____No
Age he/she began: Crawling _____ Walking _____ Talking - single words _____ 2+ word sentences _____
This child's overall development is occurring: _____Slowly _____Normally_____Quickly

Medical History

Heart problems Y or N If Yes, please explain:_____
Lung problems Y or N If Yes, please explain:_____
Eye problems Y or N If Yes, please explain:_____
Ear infections/tubes Y or N If Yes, please explain:_____
Speech problems Y or N If Yes, please explain:_____
Sensory problems Y or N If Yes, please explain:_____
Broken bone(s) Y or N If Yes, please explain:_____
Surgery Y or N If Yes, please explain:_____
Allergies Y or N If Yes, please explain:_____
Asthma Y or N If Yes, please explain:_____
Seizures Y or N If Yes, please explain:_____
Head injury/concussion/unconsciousness Y or N If Yes, please explain:_____
Other:_____
Are his/her immunizations current? Y or N If No, please explain:_____
If this adolescent has been/is on psychoactive medication, how old was he/she when it was first prescribed? _____
By whom? _____ For what? _____

_____

Current regularly used medications, including prescriptions, over-the-counters, herbals, and/or essential oils:

Medication	Dosage	Times/Day	For what reason

Additional prescription medications used in the past:

Medication	For what reason	Reason for discontinuation

Academic History

Current grade (or most recently completed)?_____ School and ISD?_____
Has he/she ever repeated a grade? Y or N If Yes, what grade(s)?_____ Who initiated retention? _____
Why?_____
Has this adolescent ever received RtI, 504, Special Education (IEP), or other intervention services? Y or N If Yes, how was he/she qualified and what service(s) did he/she receive?_____

Is this adolescent currently experiencing academic problems? Y or N If Yes, please explain:_____

Please describe what kind of grades/marks he/she is currently receiving in school:_____

Has this adolescent ever received any formal testing through the school, apart from standardized testing? Y or N If Yes, please explain:_____

Does this adolescent exhibit behavioral problems at school? Y or N If Yes, please explain:_____

Has he/she ever received detention, in school suspension, out of school suspension, or expulsion? Y or N If Yes, please explain:_____
At what level do you estimate your adolescent's intelligence? _____below average _____average _____above average

Mental and Emotional History

SYMPTOM	Y	N	ST	COMMENTS
Attention problems				
Hyperactivity				
Impulsivity				
Academic problems				
Failing classes				
Communication problems				
Language/speech problems				
Memory problems				
Anger				
Anxiety				
Panic attacks				
Depression/sadness				
Negative self-talk				
Low self-esteem				
Irritability				

Low frustration tolerance				
Threatens to harm self				
Acts of self-harm (i.e., cutting)				
Suicidal thoughts				
Manipulative tendencies				
Elevated moods/mania				
Mood swings				
Obsessive-compulsive tendencies				
Repetitive behavior				
Restricted pattern/range of interests				
Trouble with change and/or transitions				
Aggression - verbal and/or physical				
Defiance/intentional breaking of rules				
Alcohol/substance use and/or abuse				
Sexualized behavior				
Temper tantrums				
Emotional outbursts/meltdowns				
Lying				
Stealing				
Disrespectful toward adults				
Threatens to harm others				
Toileting accidents/bedwetting				
Poor hygiene				
Nightmares/terrors				
Sleep difficulties				
Hears things that are not there				
Sees things that are not there				
Difficulty making/keeping friends				
Poor social skills				
Lacks empathy				
Other difficulties				

Please provide elaboration on any specific symptom(s) which warrants direct intervention: _____

_____

_____

Has this adolescent been abused? Y or N (circle one and all that may apply)

Sexually Verbally Physically Mentally Emotionally Other: _____

When? _____ Who was the abuser? _____

Has this adolescent experienced any other traumatic event(s)? Y or N If Yes, please explain: _____

_____

Is your adolescent sexually active? Y or N If Yes, please explain: _____

_____

Have there been any significant deaths or losses in the family? Y or N If Yes, please explain: _____

_____

Has this child ever participated in therapy? Y or N Play Individual Family Group Undergone formal testing? Y or N

With whom? _____ When? _____ How long? _____

Was a diagnosis assigned? Y or N. If yes, what? _____

Was the previous treatment beneficial? Y or N or Somewhat Please explain: _____

_____

_____

Has your adolescent ever been admitted for inpatient psychiatric care? Y or N If Yes, please provide details regarding admission dates, precipitating events, treatment received, perceived benefit, etc. _____

_____

_____

_____

Parenting

Do you believe you do an effective job parenting this adolescent? Y or N Please explain:_____

_____

What discipline technique do you use that is most effective?_____

Least effective:_____

Do adults/caregivers in this adolescent's life agree on how to discipline him/her? Y or N Is this a problem for you, this adolescent, and/or your family? Y or N Please explain:_____

_____

Strengths and Weaknesses

What do you think are this adolescent's biggest personal strengths?

1. _____

   _____

2. _____

   _____

3. _____

   _____

What do you think are this adolescent's biggest personal weaknesses/limitations?

1. _____

   _____

2. _____

   _____

3. _____

   _____

Please provide any additional information you think we need to know.

_____

_____

_____

_____

_____

_____

_____

Signature and Date

Dear Young Man or Woman (Patient),
To help us understand your position on entering into therapy and/or participating in an assessment, please complete the following form to the best of your ability. Please try to do so independently. Thank you and we look forward to working with you!

What do you think is your biggest problem(s) you might need to work on in therapy, or why you should undergo testing? _____

Do you think therapy and/or testing can help you? Please explain. _____

How do you get along with your family? _____

How do you do socially? Do you have friends? What do you do for fun with your friends? _____

How do you do in school? Do you get along with teachers and classmates? _____

Do you think you do a good job dealing with stress? What do you do to cope with stress? _____

Please indicate if yes, no, or sometimes you experience the following symptoms:

SYMPTOM	Y	N	ST	COMMENTS
Attention problems				
Hyperactivity				
Impulsivity				
Academic problems				
Memory problems				
Anger				
Anxiety				
Panic attacks				
Depression/sadness				
Suicidal thoughts				
Cutting				
Irritability				
Low frustration tolerance				
Mood swings				
Aggression - verbal and/or physical				
Defiant behavior				
Lying				
Stealing				
Alcohol/substance use				
Disrespect to adults				
Difficulty making friends				
Seeing/hearing things others do not				

Thank you for taking this time to complete this form! _____

Signature and Date