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 histories. There is also a short form for your son or daughter to complete independently. 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? _____________
____
____

Frequency of visitation/contact with parent/guardian(s) in second household (if applicable): ___________________
____

Parents'/Legal Guardians' Marital Status: Married Divorced Separated Never Married Other:____________
If separated or divorced, how old was your adolescent at that time? _________ How did he/she adapt? ____________
____
____
____

Maternal Family Psychiatric History (If so, who?)
Depression/sadness________________________
Suicidal ideation/attempt____________________

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_______________________

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_______________________

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

Please indicate if Yes, No, or Sometimes (ST) your child experiences the following symptoms:

SYMPTOM	Y	N	ST	COMMENTS
Attention problems				
Hyperactivity				
Impulsivity				
Academic problems				
Failing classes				
Communication problems				
Language/speech problems				
Memory problems				
Anger				
Anxiety				
Rages				
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				
Externalizes blame				
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				
Threatens to harm others				
Defiance/intentional breaking of rules				
Alcohol/substance use and/or abuse				
Sexualized behavior				
Temper tantrums				
Emotional outbursts/meltdowns				
Lying/deceitfulness				
Stealing				
Disrespect toward adults				
Daytime toileting accidents				
Bedwetting				
Sleep difficulties				
Nightmares/terrors				
Poor personal hygiene				
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

Patient

Consenting Guardian Initials

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				
Rages				
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