COMPREHENSIVE OUTPATIENT SERVICES INC. CFD ______ CRCC _____ RCC _____ SBCC _____

Please take a moment to fill out the following medical and social history for your child. It is our policy to ask of every patient to have a physical exam as part of treatment. If you have not had a general check up in the past 12 months, you are encouraged and may be expected to get one. You will also be asked to sign an information consent form so that we may send for a copy of your medical records.

AGE: _______ HEIGHT: ____________ WEIGHT: __________ SEX: ________

EMERGENCY CONTACT: NAME, PHONE NUMBER ____

CURRENT PHYSICIAN OR PEDIATRICIAN: ____

ADDRESS: ____

____TELEPHONE #:____________________

LAST MEDICAL EXAM: ____

(PLEASE **DO NOT LEAVE THIS SPACE BLANK** – INCLUDE YEAR AND PLACE OF EXAM)

HOSPITALIZATIONS:

DATE	HOSPITAL	DESCRIPTION (REASON FOR ADMISSION):

Medical Problems (past and present): ____

____

____

CURRENT PSYCHIATRIC MEDICATIONS:	PRESCRIBED BY:

PAST PSYCHIATRIC MEDICATIONS:	PRESCRIBED BY:

History of reaction to psychiatric medications: (DRUG ALLERGIES): ____

____

NAME ____ DATE OF BIRTH ________________

COMPREHENSIVE OUTPATIENT SERVICES INC. **CFD ______ CRCC _____ RCC _____ SBCC _____**

OTHER MEDICATIONS, INCLUDING OVER THE COUNTER MEDICATIONS:	PRESCRIBED BY:

History of reactions to non-psychiatric medication (drug allergies): ____

____

____

CURRENT SYMPTOMS: answer Yes of No unless otherwise specified.

1. Recent weight gain ______ How much ______ over ______ weeks, months, years.
Weight loss ______ How much ______ over ______ weeks, months, years.

2. General weakness: ______

3. Pain: where? ________________ Severity (scale 1-10 with 1 being minimal and 10 being most severe) _____
Frequency _______________

4. Anemia ___________

5. Diabetes _______ Type ________

6. Nutritional problem ____________________________________

7. Neurological problem _______ Describe ____
History of stroke _________

8. Thyroid problem _______________________

9. Hepatitis ______ Type _________________________

10. Chronic viral illness ________ Type ______________________________

11. Headaches ______ if yes, how often ________, description ____

12. Any dizziness ______ fainting ________seizures ________

13. Any visual problems ______ glasses used ______

14. Any hearing problems ______ hearing aids used ______

15. Any skin problems ______

16. Any chest pain ________ Do you have high blood pressure __________

NAME ____ DATE OF BIRTH _________________

CURRENT SYMPTOMS (continued): answer Yes of No unless otherwise specified.

17. Any breathing problems ______asthma ______tobacco ______

18. Allergies: to what? ____

19: Any stomach or bowel problems ________ constipation ________ diarrhea ______

20. Any problems with urination ________
If female: L.M.P. ______regular ______painful menstruation ______PMS________
# of pregnancies ______abortions ______live births________
birth control method____

21: If female: inability to have orgasms ______________
If male: impotence. ____________________

HISTORY OF PARENTS

	MOTHER	FATHER	STEP-PARENT (if living with child)
FULL NAME			
MAIDEN NAME			
PLACE OF BIRTH			
RELIGION			
PRESENT MARITAL STATUS			
DATE OF MARRIAGE			
NAME OF SPOUSE			
DATE OF DIVORCE / SEPARATION			
EDUCATION COMPLETED			
HIGHEST GRADE OF DEGREE			
FIELD OF INTEREST			
OCCUPATION			
DESCRIPTION			
ANY ILLNESSES (medical, psychiatric & substance abuse)			
HOSPITALIZATIONS			
DATES			

NAME ____ DATE OF BIRTH ______________

COMPREHENSIVE OUTPATIENT SERVICES INC. CFD ______ CRCC _____ RCC _____ SBCC _____

HISTORY OF GRANDPARENTS

	MATERNAL	PATERNAL	STEP-PARENT ONE	STEP-PARENT TWO
GRANDMOTHERS				
OCCUPATION				
AGE				
CITY OF RESIDENCE				
MAJOR ILLNESSES(medical, psychiatric, substance abuse)				
DATE OF DEATH (if applicable)				
CAUSE OF DEATH (if applicable)				
GRANDFATHERS				
OCCUPATION				
AGE				
CITY OF RESIDENCE				
MAJOR ILLNESSES(medical, psychiatric, substance abuse)				
DATE OF DEATH (if applicable)				
CAUSE OF DEATH (if applicable)				

SCHOOL AND HOME INFORMATION

Please give complete information for the following questions.

NAME OF SCHOOL: ____________________ TELEPHONE #: ____________________

ADDRESS OF SCHOOL: ____________________
STREET TOWN STATE ZIP CODE

CIRCLE SCHOOL GRADE: NURSERY / KINDERGARTEN / SPECIAL CLASS / 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10 / 11 / 12

HAVE ANY GRADES BEEN REPEATED?: YES / NO IF YES, WHICH?: ____________________

FULL NAME OF COUNSELOR: ____________________

FULL NAME OF TEACHER: ____________________

LIST ALL PEOPLE (EXCEPT PARENTS) *CURRENTLY* LIVING IN HOUSEHOLD.
For siblings, note if they are foster, adopted, or step and school grade.

NAME	SEX	AGE	DATE OF BIRTH	RELATIONSHIP TO CHILD	SCHOOL GRADE OF SIBLINGS

NAME ____________________ DATE OF BIRTH ____________________

COMPREHENSIVE OUTPATIENT SERVICES INC. CFD ______ CRCC _____ RCC _____ SBCC _____

SIBLINGS NOT LIVING IN HOUSEHOLD (as above): ____

____

____

HAS ANYONE IN THE IMMEDIATE FAMILY (including the child) HAD CONTACT WITH ANY SOCIAL AGENCY OR THERAPIST, CLINIC OR PRIVATE? IF YES, PLEASE LIST:

FAMILY MEMBER	**THERAPIST OR AGENCY**	**ADDRESS**	**DATES**

HAS THE CHILD HAD ANY INVOLVEMENT WITH THE POLICE OR COURT? YES ____ NO____
IF YES, EXPLAIN:

____

____

HAVE ANY OF YOUR CHILD'S BROTHERS AND SISTERS HAD ANY MAJOR MEDICAL OR PSYCHIATRIC ILLNESSES?
IF YES, PLEASE LIST:

NAME	**ILLNESS**	**DATES**

PLEASE TELL IN YOUR OWN WORDS WHAT CONCERNS YOU HAVE ABOUT YOUR CHILD AND WHEN THESE PROBLEMS BECAME NOTICEABLE

NAME ______________________________ DATE OF BIRTH ________________

COMPREHENSIVE OUTPATIENT SERVICES INC. CFD ______ CRCC _____ RCC _____ SBCC _____

IN YOUR OPINION, WHAT ARE THE CAUSES OF THE CHILD'S DIFFICULTIES?

IN WHAT WAY DO YOU HOPE THAT WE CAN BE OF HELP?

NOTE SOME OF YOUR CHILD'S STRENGTHS, SKILLS, ABILITIES AND POSITIVE QUALITIES.

ARE YOU INTERESTED IN HAVING MORE INFORMATION ABOUT SUPPORT GROUPS? YES ____NO ___
(If you answer "yes," please talk with your therapist to obtain more information.)

WHO IS/ARE THE LEGAL GUARDIAN(S) FOR THIS CHILD? ____

WHO HAS PHYSICAL CUSTODY, IF DIFFERENT FROM THE LEGAL CUSTODIAN? ______________________________________

NAME ____ DATE OF BIRTH ________________