ReBalance Therapy

Child Health History Questionnaire

*If symptoms intensify before appointment, please call 911 or go to the emergency room.*

*The following information will be reviewed by the clinician. Please complete each section to the best of your ability and submit PRIOR to the appointment.*

Presenting Problem:

Please briefly describe reason for this visit:

Current Medications:

Please list current medications and daily dosage, including over the counter meds, vitamins, herbs, and supplements:

Past Psychiatric Medications:

Please list any previous medications, including how long the medication was taken, beneficial effects, side effects, and reason discontinued:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Benefits** | Side Effects | **Reason Discontinued** | **Time** |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |

Allergies/Adverse Reactions:

Behavioral Health History:

Has the client had past or current outpatient behavioral health treatment: Yes/No  
 Provider/Date

|  |  |
| --- | --- |
| Individual Therapy |  |
| Family Therapy |  |
| Medical Management |  |
| Psychological Testing |  |
| Psychiatric Hospital Admission |  |

Additional Behavioral Health History:

Current Living Situation:

Who is living in the home and their relationship to the patient:

Cultural / Ethical / Spiritual Considerations / Identities”

Unknown Family History / Child is Adopted: Yes/No

Does the child or a family member have a history of prior diagnosis of:

**Child Family Member**

|  |  |  |  |
| --- | --- | --- | --- |
| ADD/ADHD |  |  | Bro/sis/mom/dad/other |
| Autism Spectrum Disorder |  |  | Bro/sis/mom/dad/other |
| Bipolar Disorder |  |  | Bro/sis/mom/dad/other |
| Depression |  |  | Bro/sis/mom/dad/other |
| DMDD |  |  | Bro/sis/mom/dad/other |
| Eating Disorder |  |  | Bro/sis/mom/dad/other |
| Encopresis/Enuresis |  |  | Bro/sis/mom/dad/other |
| Generalized Anxiety |  |  | Bro/sis/mom/dad/other |
| Learning Disability |  |  | Bro/sis/mom/dad/other |
| Mania |  |  | Bro/sis/mom/dad/other |
| Obsessive-Compulsive Disorder |  |  | Bro/sis/mom/dad/other |
| Oppositional Defiant Disorder |  |  | Bro/sis/mom/dad/other |
| Panic Attacks |  |  | Bro/sis/mom/dad/other |
| PTSD/Trauma |  |  | Bro/sis/mom/dad/other |
| Schizophrenia |  |  | Bro/sis/mom/dad/other |
| Separation Anxiety |  |  | Bro/sis/mom/dad/other |
| Substance Use/Dependence |  |  | Bro/sis/mom/dad/other |
| Tourette’s |  |  | Bro/sis/mom/dad/other |
| Other (specify please) |  |  | Bro/sis/mom/dad/other |
| Other (specify please) |  |  | Bro/sis/mom/dad/other |

Medical History:

Pediatrician: Yes/No

Pediatrician Name:

Pediatrician phone number:

Date of last p

physical exam:

Date of last dental exam:

Date of last vision exam:

Additional healthcare providers: Yes/No

Has the child received immunizations? Yes/No/Unknown

Are the child’s immunizations up to date? Yes/No/Unknown

Has the child or a family member been diagnosed with:

Child Family Member

|  |  |  |  |
| --- | --- | --- | --- |
| Anemia |  |  | Bro/sis/mom/dad/other |
| Asthma |  |  | Bro/sis/mom/dad/other |
| Cancer/Leukemia |  |  | Bro/sis/mom/dad/other |
| Cerebral Palsy |  |  | Bro/sis/mom/dad/other |
| Diabetes |  |  | Bro/sis/mom/dad/other |
| Down’s Syndrome |  |  | Bro/sis/mom/dad/other |
| Ear Infection |  |  | Bro/sis/mom/dad/other |
| Encephalitis |  |  | Bro/sis/mom/dad/other |
| Epilepsy/Seizures |  |  | Bro/sis/mom/dad/other |
| Fever above 150 |  |  | Bro/sis/mom/dad/other |
| Hearing Problems |  |  | Bro/sis/mom/dad/other |
| Heart Problems/Disease |  |  | Bro/sis/mom/dad/other |
| HIV/AIDS |  |  | Bro/sis/mom/dad/other |
| Hydrocephalus |  |  | Bro/sis/mom/dad/other |
| Lead Poisoning |  |  | Bro/sis/mom/dad/other |
| Liver Disease |  |  | Bro/sis/mom/dad/other |
| Loss of Consciousness/Head Injury Meningitis |  |  | Bro/sis/mom/dad/other |
| Musculo-Skeletal Condition |  |  | Bro/sis/mom/dad/other |
| Strep Infection |  |  | Bro/sis/mom/dad/other |
| Stroke |  |  | Bro/sis/mom/dad/other |
| Thyroid Problems |  |  | Bro/sis/mom/dad/other |
| Vision Problems |  |  | Bro/sis/mom/dad/other |
| Other (specify please) |  |  | Bro/sis/mom/dad/other |
| Other (specify please) |  |  | Bro/sis/mom/dad/other |

Does the child have an eating or sleeping problem (circle all that apply):

-dieting

-overeating

-undereats

-picky eater

-recent weight gain

-recent weight loss

-refuses to eat

-vomiting

-bedwetting

-difficulty falling asleep

-does not want to sleep alone

-sleeps too much

-nightmares

-soiling

-trouble staying asleep

-restless at night

-other (specify):

How would you describe the nutritional value and balance of the child’s diet: Good/Fair/Poor

Examples of a typical diet:

Breakfast:

Lunch:

Dinner:

Does the child have any of the following:

1. Cognitive Issues:

-lack of varied, spontaneous make-believe play

-restricted patterns of behavior, activities, or interests

-repetitive patterns of behavior, interest, or activities

-preoccupation with parts of an object

-cognitive disabilities

-intense/all-encompassing interest

2. Sensory Issues:

-overly sensitive to sounds

-other sensory issues

-coordination problems

Developmental History:

Prenatal/Birth

Health of mother during pregnancy: Good/Fair/Poor/Unknown

Parental ages at time of birth: Mother: Father:

Did mother use any of the following during pregnancy: Yes/No/Unknown

-cigarettes

-prescription drugs (please list):

-alcohol

-coffee/caffeine drinks

-cocaine/crack/

-marijuana

Any medical complications during pregnancy: Yes/No/Unknown

Length of pregnancy:

-Full term

-Late preterm (32-36 weeks)

-Very preterm (28-31 weeks)

-Extremely preterm (less than 28 weeks)

-Unknown

Birth Weight:

Were the any complications during or following birth? (select all that apply)

-baby given oxygen

-baby on heart monitor

-birth defects

-blood transfusions

-delivery aided by instruments

-delivery by cesarean section

-incubator

-jaundice

-problems breathing

-problems eating/digestion

-problem sucking

-rashes

-very active

-very quiet

-other (please specify)

Early Development:

What age did the child begin:

-walking (months):

-talking (single words):

-talking (short sentences 2+ words):

-running (months):

-toilet training day-time:

-toilet night-time:

Can child throw a ball: Yes/No

Can child catch a ball: Yes/No

Child had no trouble learning to hold a pencil: Yes/No

Child easily learned to zip to zippers, tie shoes and button clothes: Yes/No

During the first three years of life, the child frequently exhibited:

-accident prone behavior

-avoidance of cuddling

-colic

-distractibility

-extreme mood changes

-problems with sleeping/walking patterns

-feeding problems

-lack of coordination

-overactive behavior

-restless behavior

-self-hurting behavior

-temper tantrums

-head banging

-unresponsive to discipline

Activities of Daily Living:

Assigned chores or responsibilities: Yes/No

Needs prompting (please describe): Yes/No

Promoting self-care appropriate for age level:

Needs prompting (please describe): Yes/No

Does the child drink alcohol: Yes/NO

Smoking Status:

Vaping: Yes/No

Others smoking in home: Yes/No

Educational History:

Highest grade level completed:

Current grade:

Name of school presently attending:

Number of schools previously attended:

School related issues (select all that apply):

-504 plan

-advanced a grade

-academic problems

-attendance

-behavior

-bullying

-detention

-expulsion

-IEP

-held back a grade

-homework

-learning disabilities

-met with school counselor

-occupational therapy

-peer relationships

-physical therapy

-relationships with teacher(s)

-required special help

-school modifications

-speech therapy

-suspension (in school)

-suspension (out of school)

-tested by school psychologist (ADD, ADHD, other)

-transportation

Please describe and include any additional educational stressors:

Additional Social History:

How easy is it for the child to make friends: more difficult, average, easier than average

How does the child get along with siblings: more difficult, average, easier than average

What are the child’s strengths:

Please describe extracurricular activities, employment and other pertinent information

Thank you for taking the time to complete this questionnaire.

Completed by:

Date:

Relationship to patient: self/parent/guardian/other