Name: _____ Date: _____

Hospitalizations

Nature of hospitalization: ☐ Medical ☐ Psychiatric ☐ Substance Abuse
Facility, Location: _____
Dates, Length of stay: _____
_____

Long-term/residential treatment: ☐ Yes ☐ No Dates_____
Facility/Location: _____

Developmental History

Prenatal / Postnatal complications: ☐ Yes ☐ No
If yes, please describe: _____

☐ Delayed Motor Development ☐ Delayed Speech ☐ Premature Birth
☐ Physical / Occupational / Speech Therapy

Please describe: _____
_____

Areas of Concern

Indicate if you (or your child, if minor is the patient) have a history or current concerns regarding:

☐ Social Skills
☐ Toileting Accidents
☐ Tics
☐ Frequent headaches
☐ Restlessness/hyperactivity
☐ Unusual / troublesome thoughts
☐ Withdrawal / isolation
☐ Violent/Aggressive Behaviors
☐ Suicidal thoughts
☐ History of trauma
☐ Academics/learning
☐ Bedwetting
☐ Nail biting
☐ Stomach aches
☐ Mood fluctuations
☐ Hallucinations
☐ Poor concentration
☐ Dangerous Behaviors
☐ Attempted suicide
☐ History of abuse (physical, sexual, emotional)
☐ Nightmares
☐ Anxiety
☐ Fatigue
☐ Depressed mood
☐ Racing thoughts
☐ Attention
☐ Self-injury

If yes, please describe: _____
_____

Has the Department of Child and Family Services (DCFS) been involved with your family (current or past)? ☐ Yes ☐ No
If yes, please describe: _____
_____