Reclaim Mental Health, LLC
Akiva Daum, MD FAPA
Board Certified General and Addiction Psychiatry
www.reclaimmh.com

3275 W Hillsboro Blvd, Suite 300D
Deerfield Beach, FL 33442
Phone: (954) 451-2592
Fax: (888) 490-0705

CHILD HISTORY QUESTIONAIRE

(Please be as descriptive as possible. If you are not comfortable writing information, you can certainly share it in session. The more we know about where you struggle, the more we can offer assistance)

Date_____ Date of Birth_____

Name_____ Age_____

Presenting problem_____

Early Childhood Information

Complications or unusual events at birth_____

Any delays in developmental milestones_____

Details about growing up: _____

Parents: Married [ ] Never Married [ ] Divorced [ ] Separated [ ] Other [ ] Mark if living Mother [ ] Father [ ]

Quality of their relationship? _____

Adopted [ ] If so, do you know about your biological parents? _____

How do you relate to your mother?

_____

How do you relate to your father?

_____

Do you have siblings Yes [ ] No [ ] Do any siblings have disabilities or developmental problems Yes [ ] No [ ]

Describe your childhood

_____

_____

_____

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Describe your adolescence

_____

_____

Any traumatic events Yes [ ] No [ ]

If yes:

_____

Other significant information

_____

Medical History

Medical Hospitalizations Yes [ ] No [ ] Psychiatric Hospitalizations Yes [ ] No [ ] Residential, PHP, IOP Yes [ ] No [ ]

If so, what for? _____

_____

_____

_____

☐Hepatitis C	☐History of strokes	☐Heart disease	☐High blood pressure	☐Diabetes
☐Chronic Pain	☐Seizure Disorder	☐Nutritional issues	☐History of heart attack	☐Anemia
☐Sleep disorder	☐Fertility issues	☐Bleeding disorder	☐High cholesterol	☐other

_____

Allergies_____

Current Medications_____

_____

_____

_____

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Pediatrician/Primary Care Provider_____

Previous psychiatric care Yes [ ] No [ ] Psychotherapy Yes [ ] No [ ] When_____

With whom_____

Eating problems Yes [ ] No [ ]

If so, please ellaborate_____

_____

Sleeping problems Yes [ ] No [ ]

If so, please ellaborate_____

_____

History of suicide attempts Yes [ ] No [ ] History of self-injurious behaviors Yes [ ] No [ ]

If so, please ellaborate_____

_____

Do you currently have suicidal thoughts Yes [ ] No [ ]

If so, please ellaborate_____

_____

Do you have a history of physical/emotional/sexual abuse or trauma Yes [ ] No [ ]

If so, please ellaborate_____

_____

Is there other information you think I should know_____

_____

Family history of mental illness_____

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Substance Use

Are you a tobacco user? Yes [ ] No [ ] Do you vape nicotine? Yes [ ] No [ ]

Would you like to quit? Yes [ ] No [ ] Unsure [ ] Other_____

Alcohol Yes [ ] No [ ]

If so, please ellaborate_____

_____

Cannabis Yes [ ] No [ ]

If so, please ellaborate_____

_____

Sedatives (Benzodiazepines, Muscle relaxers, etc) Yes [ ] No [ ]

If so, please ellaborate_____

_____

Opioids Yes [ ] No [ ]

If so, please ellaborate_____

_____

Cocaine Yes [ ] No [ ]

If so, please ellaborate_____

_____

Hallucinogens Yes [ ] No [ ]

If so, please ellaborate_____

_____

Is there other information you think I should know_____

_____

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School History

Current grade in school_____ Where_____

Type of student/grades_____

Previous Schools Attended_____

Any identified learning problems Yes [ ] No [ ]

If so, please ellaborate_____

_____

Any issues with completing homework Yes [ ] No [ ]

If so, please ellaborate_____

_____

Any refusal to attend school Yes [ ] No [ ]

If so, please ellaborate_____

_____

Describe Current School/Activities/Honors_____

_____

Any suspensions/expulsions/behavioral issues Yes [ ] No [ ]

If so, please ellaborate_____

_____

Is there a teacher or another adult who you see as a role model Yes [ ] No [ ]

If so, please ellaborate_____

_____

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Is there other information you think I should know_____

_____

Work/Social/Legal History

Current Job:_____ How long have you worked there_____

Prior jobs_____ Longest Employment_____

Longest relationship_____

Have you ever been arrested Yes [ ] No [ ]

If so, please ellaborate_____

_____

Social activities_____

How many friends do you have_____ How many close friends_____

Hobbies_____

ls there excessive texting Yes [ ] No [ ]

If so, please ellaborate_____

_____

Is there excessive videogame playing Yes [ ] No [ ]

If so, please ellaborate_____

_____

Is there excessive time spent on the computer Yes [ ] No [ ]

If so, please ellaborate_____

_____

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Is there other information you think I should know_____

_____

What do you want to gain from treatement_____

Other information you wish to share_____

_____

_____

_____

_____

_____

_____

For Parents and/or legal guardians

Describe how you see your child_____

_____

How do they handle stress_____

_____

What makes them feel angry_____

_____

What makes them feel nervous_____

_____

What makes them feel sad_____

_____

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What makes them feel happy_____

_____

Is there other information you think I should know_____

_____

Other information you wish to share_____

_____

_____

_____

_____

_____

_____

_____