Child's Health Information

Has the child ever (now or in the past) received treatment for any emotional or psychological problem? Problems may include but are not limited to Anxiety, Depression, Substance Abuse, Eating Disorder, ADHD, and Autism.

◯ Yes
◯ No
◯ Don't know
((You will provide details below.))

Has the child taken any medications (prescription or over-the-counter) within the past two weeks?

◯ Yes
◯ No
◯ Don't know
((You will provide details below.))

Please list all current and past treatment and/or evaluations the child has received for any emotional or psychological problem.

Treatment 1
Problem:

_____

Type of treatment and/or medication:

_____

Start Date: _____

(Indicate month and year.) End Date: _____

(Indicate month and year.)

Treatment 2
Problem:

_____

Type of treatment and/or medication:

_____

Start Date: _____

(Indicate month and year.) End Date: _____

(Indicate month and year.)

Treatment 3
Problem:

_____

Type of treatment and/or medication:

_____

Start Date: _____

(Indicate month and year.) End Date: _____

(Indicate month and year.)

Treatment 4
Problem:

_____

Type of treatment and/or medication:

_____

Start Date: _____

(Indicate month and year.) End Date: _____

(Indicate month and year.)

Treatment 5
Problem:

_____

Type of treatment and/or medication:

_____

Start Date: _____

(Indicate month and year.) End Date: _____

(Indicate month and year.)

Treatment 6
Problem:

_____

Type of treatment and/or medication:

_____

Start Date: _____

(Indicate month and year.) End Date: _____

(Indicate month and year.)

Treatment 7
Problem:

_____

Type of treatment and/or medication:

_____

Start Date: _____

(Indicate month and year.) End Date: _____

(Indicate month and year.)

Treatment 8
Problem:

_____

Type of treatment and/or medication:

_____

Start Date: _____

(Indicate month and year.) End Date: _____

(Indicate month and year.)

Treatment 9
Problem:

_____

Type of treatment and/or medication:

_____

Start Date: _____

(Indicate month and year.) End Date: _____

(Indicate month and year.)

Treatment 10
Problem:

_____

Type of treatment and/or medication:

_____

Start Date: _____

(Indicate month and year.) End Date: _____

(Indicate month and year.)

Please list all medications the child has taken within the past two weeks.

Medication 1
Medication name: _____ Taken within the last 24 hours? _____
Reason for taking medication:

_____

Medication 2
Medication name: _____ Taken within the last 24 hours _____

Reason for taking medication:

_____

Medication 3
Medication name: _____ Taken within the last 24 hours _____

Reason for taking medication:

_____

Medication 4
Medication name: _____ Taken within the last 24 hours _____

Reason for taking medication:

_____

Medication 5
Medication name: _____ Taken within the last 24 hours _____

Reason for taking medication:

_____

Medication 6
Medication name: _____ Taken within the last 24 hours _____

Reason for taking medication:

_____

Medication 7
Medication name: _____ Taken within the last 24 hours _____

Reason for taking medication:

_____

Medication 8
Medication name: _____ Taken within the last 24 hours _____

Reason for taking medication:

_____

Medication 9
Medication name: _____ Taken within the last 24 hours _____

Reason for taking medication:

_____

Medication 10
Medication name: _____ Taken within the last 24 hours _____

Reason for taking medication:

_____