Comprehensive Psychological Services
Child/Adolescent Mental Health History Form

Name _____Date_____

Date of Birth ___/___/___ Age ____ Gender _____ Racial Identity _____

What is your understanding of why you're here today? _____

_____

What things in your life have been stressful lately? (school, family, friendships): _____

_____

Have you seen a counselor outside of school before? ( ) Yes ( ) No
If yes, what did you talk about?_____
What was helpful? What was not?_____

_____

Do you take or have you taken medication for psychiatric reasons? ( ) Yes ( ) No
Was it helpful? Side effects?_____

_____

Describe any current physical problems:_____

_____

Are you having any difficulties with sleep or unusual sleep patterns? ( ) Yes ( ) No
Describe them. :_____

_____

Family Background and Childhood History

Describe your relationship with your sibling (s), if you have any:_____

_____

Describe your relationship with your father:_____

_____

Describe your relationship with your mother:_____

_____

Educational History

Favorite subjects at school? _____
Least favorite subjects? _____
Are you bullied at school? Describe this. _____

_____

_____

Social History

Are you dating? ( ) Yes ( ) No
Describe your dating history:_____

_____

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used other than those prescribed by a doctor and used exactly as prescribed)	Age when you first used this:	How much & how often do or did you use this??	How long did you use or have you used this?	When did you last use this?	Do you currently use this?
TOBACCO: Cigarettes, Vapes, Cigars, chewing tobacco					Yes □ No □
ALCOHOL					Yes □ No □
CANNABIS: Marijuana, hashish, hash oil					Yes □ No □
STIMULANTS: Cocaine, crack					Yes □ No □
STIMULANTS: Methamphetamine—speed, ice, crank					Yes □ No □
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes □ No □
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes □ No □
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes □ No □
HEROIN					Yes □ No □
STREET OR ILLICIT METHADONE					Yes □ No □
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes □ No □
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes □ No □
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes □ No □
OTHER: specify)_____ _____ _____					Yes □ No □