Comprehensive Psychological Services
Parent/Guardian Mental Health History Form

Name of person completing this form_____

Relationship to the Child: _____Date_____

Child's: Date of Birth ___ /___/___Age ___ Gender ____ Pronouns _____Racial Identity _____

Describe briefly their present symptoms_____

_____

_____

_____

Recent family stressors (e.g., family, job, recent loss of loved one, financial issues): _____

_____

Previous psychological evaluations:_____

_____

Mental Health Services or Counseling (When? Where?):_____

_____

Psychiatric Hospitalizations (include where, when, & for what reason): _____

_____

List ALL current prescription medications and how often they take them (if none, write none)

Medication Name Daily Dosage Estimated Start Date

_____

_____

_____

_____

_____

_____

List ALL past psychiatric prescription medications

Medication Name Prescribed by: Taken when:

_____

_____

_____

_____

Current primary care provider:_____

Current medical problems: _____

_____

Past medical problems, nonpsychiatric hospitalizations, and surgeries: _____

_____

_____

Concussions, loss of consciousness, or seizures: _____

_____

Problems with sleep or appetite_____

_____

Family Background and Childhood History

Where were they born & raised? _____

_____

By whom? _____

_____

Were they adopted? ( ) Yes ( ) No If yes, are they aware? ( ) Yes ( ) No

List their siblings and ages:_____

_____

List everyone who currently lives with them:_____

_____

What is/was their father's occupation? _____

What is/was their mother's occupation?_____

Did their parents divorce? ( )Yes ( ) No If so, how old were they at time of divorce? _____

If they divorced, who do/did they live with?_____

Describe their relationship with their father:_____

_____

Describe their relationship with their mother:_____

_____

Describe their relationship with their siblings:_____

_____

Has anyone in their immediate family died? ( ) Yes ( ) No Who and when?_____

_____

Were they ever the victim of abuse? ( ) Yes ( ) No

Extended family psychiatric problems past and present: (e.g., ADHD, depression, anxiety, learning disorders, autism) _____

_____

Developmental History

Any complications during their mother's pregnancy with them or their birth? (specify)_____

_____

Any health problems at birth or in infancy? (specify)_____

Any delays with walking/talking/toilet training? (specify)_____

Testing History

Performance on IQ/achievement testing:_____

History of hearing or speech/language abnormalities:_____

Ever receive occupational or physical therapy? (specify)_____

Educational History

Current grade:_____Name of child's current school? _____

Have they ever repeated any grades? (specify) _____

504 or IEP past? ( ) Yes ( ) No Current? ( ) Yes ( ) No

Describe past/current academic accommodations: _____

_____

Does the child get bullied by peers? (specify) _____

_____

What do their teachers say about them?_____

_____

Attention problems in school? (specify) _____

_____

Behavioral problems in school? Suspended or expelled? (specify) _____

_____

Occupational History

Are they currently working? ( ) Yes ( ) No How long? _____

What is their job? _____

Where do they work? _____

Previous experience: _____

Future goals: _____

Relationship History

Are they dating? ( ) Yes ( ) No Dating history:_____

_____

MISC

Have they ever been arrested? Pending legal problems(specify)

_____

_____

Is there anything else you would like us to know? _____

_____

_____

_____

_____

_____

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used other than those prescribed by a doctor and used exactly as prescribed)	Age when first aware of use:	How much & how often did/do they use this?	How long did they use or have they used this?	When did they last use this?	Do they 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 □