Agape Youth Behavioral Health Patient Information Form

Patient Information

Child's Name	Date of Birth	Age
School	Grade	
Referring Provider		
Primary Care Doctor	Therapist (if any)	

Mental Health Concerns and History

1. Please list your child's main symptoms/behaviors of concern:

2. What is your primary goal for this appointment?

3. Check below all services that you are interested in for your child:

☐Clarification of Diagnosis ☐Medication Treatment ☐Information About Psychotherapy/Behavioral Training

4. What mental health diagnoses has your child previously been given or do you suspect?

5. List all clinics or mental health centers that your child has been treated at previously:

Clinic or Center	Estimated Dates of Visits

6. Has your child ever had inpatient or residential treatment for **mental health** symptoms? ☐ Yes ☐ No

Facility	Reason for Hospitalization	Dates of Stay

7. List **all current** medications/supplements and doses below:

Medication	Dose (how much & how often)

8. List all **past medications/supplements** used for **emotional or behavioral problems** below (use blank paper if needed):

Medication Name	Dose (how much & how often)	Date Started	Date Stopped	Why Stopped

Allergies, Medications, and Medical Concerns

1. Please list any known **medication** allergies or sensitivities: ☐ None
2. Please list any **other** known allergies (foods, seasonal): ☐ None
3. Please list any medical illnesses that your child has: ☐ None
4. Has your child ever had surgery or been hospitalized for medical reasons? ☐ Yes ☐ No

Facility	Reason for Surgery or Hospitalization	Dates

Birth and Developmental History

1. Age of biological mother at child's birth	2. Child's birth weight
3. Was biological mother exposed to toxins in pregnancy (i.e. medications, tobacco, street drugs, alcohol)? ☐ Yes ☐ No	
If yes, list toxins:	
4. Any complications during this pregnancy? ☐ Yes ☐ No List:	
5. Full-term ☐ Yes ☐ No	6. Home within 3 days of birth? ☐ Yes ☐ No
7. Please write the age at which your child was able to do the following things (if remembered)	
First walked?	Was toilet trained?
Said first words?	Used 2-3 word phrases with meaning?
8. Has your child ever had **psychological or IQ testing**? If so, please provide copies. Yes No	

Educational and Social History

1. Has your child ever received any special education services at school? ☐ Yes ☐ No		
2. Does your child have an IEP (Individualized Education Plan)? ☐ Yes ☐ No		
3. Has your child ever repeated a grade level? ☐ Yes ☐ No		
4. Has your child ever received any of the following services listed below:		
Physical Therapy ☐ Yes ☐ No	Speech Therapy ☐ Yes ☐ No	Occupational Therapy ☐ Yes ☐ No
5. Has your child had significant disciplinary actions (i.e. suspensions, expulsions) at school? ☐ Yes ☐ No		
6. Had your child had legal problems (i.e. court appearance, probation)? ☐ Yes ☐ No		
7. Is your child interested in making and keeping friends? ☐ Yes ☐ No		
8. Potential stress history for child (check all that apply):		☐ Arrest/convictions of family members
☐ Parental divorce	☐ Parent separation or marital problems	☐ Exposure to a Natural Disaster
☐ Domestic violence	☐ Serious illness in family	☐ Death in family
☐ Victim of Physical Abuse	☐ Victim of Sexual Abuse	☐ Victim of Verbal/Emotional Abuse

9. List all immediate (biological) family members. Also list others living in the home:

Relation	Name	Age	Living in Home?	Children: current grade in school Adults: highest level of education
Bio Father				
Bio Mother				

Family History

1. Please list below any biological family members of the child who have had any of the following:
   - i. Sudden death, heart rhythm problems, genetic disorders
   - ii. Autoimmune disorders (i.e. thyroid disease, lupus, multiple sclerosis)
   - iii. Psychiatric conditions (i.e. anxiety, depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, ADHD)
   - iv. Developmental conditions (i.e. mental retardation, learning problems, autistic disorders)
   - v. Neurological conditions (i.e. seizures, tics)
   - vi. Drug/alcohol problems

Relationship to Child (father, mother, brother, sister, grandmother, cousin, uncle, etc.)	Name or Description of Conditions *Please include any conditions from all of the categories listed above*