Horizons Mental Health Center
Pediatric Health History Form

Client's Name:	Date Of Birth:
What are you here for today?	
Form Completed by:	Relationship to Child:
Are you client's legal guardian? (If not, please provide name)(A15)	
Where does client currently reside? (A13)	
Who Referred You To Horizons?	Primary Care Physician:
Do You Have Friends and/or relatives working at Horizons?	

CURRENT SYMPTOMS

Please Check any of the following terms that apply to you (S= Self) or with a family member (F=Family)

S	F		S	F		S	F	
☐	☐	Depressed mood	☐	☐	Significant ongoing physical pain	☐	☐	Gambling Problems
☐	☐	Lost interest or pleasure	☐	☐	Headaches	☐	☐	Alcohol Use
☐	☐	Lack of energy/fatigue	☐	☐	Cutting	☐	☐	Drug usage
☐	☐	Weight gain or loss	☐	☐	Making Yourself Sick	☐	☐	Marital problems
☐	☐	Unable to concentrate	☐	☐	No Desire To Eat	☐	☐	Divorce
☐	☐	Excessive sleeping	☐	☐	Eating Too Much	☐	☐	Separation
☐	☐	Decreased need for sleep	☐	☐	Learning/Academic problems	☐	☐	Affair
☐	☐	Nightmares	☐	☐	Schizophrenia	☐	☐	Problems with ex/spouse
☐	☐	Racing thoughts	☐	☐	Bipolar Disorder	☐	☐	Relationship problems
☐	☐	Excessive risk taking behavior	☐	☐	Anxiety	☐	☐	Parenting problems
☐	☐	Panic Attacks	☐	☐	Alzheimer's	☐	☐	Problems with Friends
☐	☐	Excessive fear or situation or object	☐	☐	Cancer	☐	☐	Problems with children
☐	☐	Reoccurring thoughts or impulses	☐	☐	Thyroid Disease	☐	☐	Legal problems
☐	☐	Repetitive behaviors to reduce stress	☐	☐	Stoke	☐	☐	Work/job problems
☐	☐	Witness/experience event threatening life or serious injury	☐	☐	Diabetes	☐	☐	Financial problems
			☐	☐	Hypertension	☐	☐	School problems
☐	☐	Excessive anxiety or worry	☐	☐	Heart Disease	☐	☐	Incarceration
☐	☐	Hear/see things others do not	☐	☐	Impulsive behaviors	☐	☐	Anger
☐	☐	Memory problems/ Memory loss	☐	☐	Temper	☐	☐	Loneliness
☐	☐	Suicidal Thoughts	☐	☐	Aggressive behavior toward others	☐	☐	Insecurity
☐	☐	Sexual problems	☐	☐	Frequent lying/deceitfulness	☐	☐	Isolation

PREGNANCY AND BIRTH

Please indicate any medical problems during pregnancy or in newborn state:				
Type of delivery:	Birth Weight:		Birth Length:	
APGAR Score:	Due Date:		Mother's age at pregnancy:	
Did mother use substances during pregnancy (Alcohol, Drugs, Tobacco, etc)?				
Please list sibling's ages and health status:				
Developmental Milestones(Please list age)				
Sat Alone:	Crawled:	Walked:	Used Sentences:	Toilet Trained:
Are immunizations current?				

SCHOOL INFORMATION

Name of School:	Current Grade (A10):
Concerns about school performance? (A9)	
Is the child involved in special education or behavioral disorder classes(IEP, 504, etc) (A7):	

In the past 30 days		
# Absences:	# Excused:	# Unexcused:
# Suspended(Please List) (A11):	# Expelled(Please List):	

*Attach list if you have more meds to list than the space allows

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PERSONAL HISTORY

Hours of sleep per night:	Amount of TV per day:	Bedwetting or soiling:
Nail biting:	Amount of computer/video games per day:	Amount of physical activity per day:

MEDICAL HISTORY

Please List Any Past or Current Contacts with Doctors, Psychiatrists, or Therapists:		
Name of Provider	**Reason for Service**	**Dates of Services**

Have You Ever Been Hospitalized For Your Mental Health Status? If So, Please List(Place and Date) (A1):		
Hospital Name	**Place**	**Dates**

Please list all Medications:		
Current Medication	**Strength/Dose/Schedule**	**Prescriber/Start Date**

Please list Previous Psychiatric Medications:		
Please List Any Known Allergies:		
Are you Pregnant?	Current Form of Birth Control:	Age of first menstrual period:
History Of Serious Illness, Injury or Surgery (Please list):		

Review Of Systems: Please circle if any of the problems apply within the past 30 days:

Numbness/Tingling	Joint Problems	Stomach Pain	Rash or Hives
Headaches	Muscle Pain	Nausea/Vomiting	Eczema
Tremors	Muscle Weakness	Chest Pain	Psoriasis
Dizziness	Kidney Infection/Stone	Rapid Heart Beat	Shortness Of Breath
Vision Problems	Bladder Infection	High/Low Blood Pressure	Involuntary Movements
Hearing Problems	Difficulty Urinating	Weight Gain Or Loss	Fever
Insomnia	Constipation	High/Low Blood Sugar	Other:
Seizures	Diarrhea	Thyroid Problems	Other:

SUBSTANCE USE

Use of Illegal Drugs, Tobacco Products, or Alcohol (Current or Previous use)? ☐ Yes ☐ No			
Name of Substance	Age of first Use	Amount and Frequency	Date of last use

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SOCIAL HISTORY

What Is Your Highest Level Of Education? : (A4)		
Name of Employer:	Job Title:	
Have You Been Arrested In The Last 30 Days? If So, Please List Reason: (A16) Are You Currently Involved With Court Services (Parole, Community Corrections, Etc) (If So Please List):		
Date	Reason	Convicted?

ABUSE HISTORY

Has anyone abused you physically, sexually or emotionally? ☐ Yes ☐ No		
Type (Physical/Sexual/Emotional)	When did it start (how old were you?)	Is it Ongoing?
Has the client been involved in any DCF Reports?(Please list all dates) (A5)		

Client or Guardian Signature _____ **Date** _____

OFFICE USE ONLY:

Signature Of Reviewing Clinical/Medical Staff _____ Date Reviewed _____

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