MINOR'S MEDICAL HISTORY

Client Name: ___________________________________ Date of Birth: ________________________

*Please explain any "yes" answers below.

Family Psychiatric History ☐ Yes ☐ No

Depression ☐ Yes ☐ No

Anxiety ☐ Yes ☐ No

Suicidal ☐ Yes ☐ No

Homicidal ☐ Yes ☐ No

Family Medical History ☐ Yes ☐ No

Birth/Development ☐ Yes ☐ No

Allergies ☐ Yes ☐ No

Cardiac ☐ Yes ☐ No

MINOR'S MEDICAL HISTORY

Asthma	☐ Yes	☐ No
Migraines	☐ Yes	☐ No
Sleep Problems	☐ Yes	☐ No
Behavioral	☐ Yes	☐ No
Neurologic	☐ Yes	☐ No
Weight	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No

Completed by: ____ Date ____________________________

History Reviewed Initials: ________________ Date: __________________