Central Square Therapy Associates

Developmental History Form

Date: _____

Patient's Name: _____ Parent(s) Name(s): _____
(If under 18)

Date of Birth: _____ Social Security Number: _____

Who referred you / your child to our clinic? _____

What are your concerns? _____

_____

Identifying Information

Age: _____ Gender: _____Male _____Female

Patient's Address: _____

Patient's Telephone #: (Home)_____ (Work) _____

Patient's E-mail Address: _____

Emergency Contact: _____ at Telephone #: _____

Patient's Primary Language: _____ Interpreter Required? ___Yes ___No

Are other agencies involved? ___Yes ___No
If yes, please specify agency(ies)

Please describe in your own words what concerns you about yourself / your child, and how you hope we can be of help. Please add all information you believe is important and may be helpful in our assessment and treatment.

_____

_____

_____

_____

OFFICE ADDRESS: 150 MARKET STREET 2ND FLOOR, LYNN, MA 01901
PHONE #: (781) 592-6100 FAX #: (781) 592-1093

Self-Maintenance

Appetite:
Weight _____ loss _____ gain _____ how long _____ meals per day _____

Sleep:
Hours _____ interrupted _____ sound _____ not sound _____ how long _____

Mood:
Euthymic___ Depressed ___ Anxious ___ Euphoric___ Hostile___ Irritable___ Panic___

Fearful___ Overwhelmed___ Angry___ Other_____

Hallucinations:
Not Present___ Auditory___ Visual___ Olfactory___ Tactile___ Gustatory___ Denies___

Delusions:
Not Present___ Persecutory___ Being Controlled___ Grandiose___ Somatic___ Bizarre___

Thought Insertion/Deletion___ Denies___

Suicidal Ideation:
Denies___ Vague/Passive___ With Impulse___ Plan___

Memory:
Intact___ Impaired: Immediate___ Recent___ Remote___ Amnesia: Partial___ Global___

Comments: _____

_____

_____

Medical History

Primary Care Physician's Name: _____

Address: _____

Telephone #: _____

Would you like for us to communicate our findings with your PCP? ___Yes ___No

Are there any concerns about the patient's physical health? ___Yes ___No
If so, please describe:

Has the patient has any surgeries? ___Yes ___No
If so, please describe:

Is the patient currently being treated for any acute or chronic medical condition? ___Yes ___No
If so, please describe:

Does the patient have any history of injuries or accidents? ___Yes ___No
If so, please describe:

Psychiatric History

Is patient currently in treatment for an emotional or behavior problem? ___Yes ___No
If yes, please list current providers.

Therapist's Name & Address: _____

Therapist's Phone #: _____

Do you give permission for us to speak with your child's / your current therapist? ___Yes ___No

Is the patient currently taking medication for an emotional or behavioral problem? ___Yes ___No
If yes, please list medications and prescriber:

Prescriber's Name & Address: _____

_____

Prescriber's Telephone #: _____

List Medication Taken: _____

Do you give us permission to speak with your child's / your current Prescriber? ___Yes ___No

Has the patient ever required treatment in a psychiatric hospital or residential treatment facility? ___Yes ___No
If yes, please list:

Dates	Hospital / Residential	Reason for Placement	Outcome

Has the patient ever taken medications to help behaviors or emotions? ___Yes ___No
If yes, please provide a detailed chronology of the medications your child / you have been treated with. Also add if medications were taken alone or in combination with other medicines. Use the other side of this page, if necessary. Please describe any unusual or adverse side effects.

Date	**Medication**	**Reason for Taking**	**Dosage**	**How well did it work?**	**Any side effects?**

Has the patient engaged in any behaviors that are dangerous to herself / himself (suicidal, ideation, attempts, self-mutilation)? ___Yes ___No
If yes, please describe:

_____

_____

Has the patient engaged in any behaviors that are dangerous to others (aggressive, threatening, hurting others)?
___Yes ___No
If yes, please describe:

_____

_____

Substance Use / Abuse History

Does the patient (to the best of your knowledge) experiment with, use, misuse, or abuse substances?
___Yes ___No
If yes, please describe:

Drug	Age Started	Frequency	Amount	Current Use?
Caffeine				
Nicotine				
Alcohol				
Cannabis				
Amphetamines				
Hallucinogens				
Cocaine				
Opiods				
Inhalants				
Phenylclidine				
Special K or Ketamine				
Sedatives (Klonopine, Xanax)				
Polysubstance				
Prescription Medication				
Others				

Has the patient ever required treatment for a substance abuse/misuse problem?
___Yes ___No
If yes, please list:

Dates	Treatment Facility	Reason for Placement	Outcome

List all current medications:

Allergies: _____ Adverse Drug Reactions: _____

Is there any known family history of unusual reactions to medications anesthesia? ___Yes ___No
If yes, please describe:

_____

_____

Are there any physical disabilities? ___Yes ___No
If yes, please list:

_____

_____

Family History

Often certain types of illnesses run in families. Is there any known history of any of the following in either mother's or father's side of family? Check all boxes that apply or mark UK for Unknown.

Has anyone in the family ever had:	Mother	Father	Sister	Brother	Extended Family
Motor or Coordination Problems?					
Problems with reading?					
Problems with math?					
Speech / Language problems					
School / Learning problems					
Autism					
Abuse (verbal, emotional, physical or sexual)					
Mental retardation					
Attention Deficit Hyperactivity Disorder					
Alcohol and / or Drug problem					
Tic Disorder or Tourette's					
Syndrome					
Enuresis (bedwetting)					
Encopresis (soiling)					
Separation Anxiety Disorder					
Selective Mutism					
Dementia (Alzheimer's)					
Catatonia					
Schizophrenia Disorder					
Delusional Disorder					
Major Depression					
Dysthymia (chronic depression)					
Bipolar Disorder or Manic Depressive Illness					
Panic Disorder					
Agoraphobia					
Obsessive-Compulsive Disorder					

Has anyone in the family ever had:	Mother	Father	Sister	Brother	Extended Family
Generalized Anxiety Disorder/Post Traumatic Stress Disorder					
Anorexia					
Bulimia					
Body Dysmorphic Disorder (multiple personalities)					
Sexual Disorder					
Sleep Disorders (insomnia, narcolepsy, Sleep apnea, sleepwalking, night terrors, etc)					
Impulsive Control Disorder (kleptomania, trichotillomania, pyromania, gambling, etc)					
Personality Disorders					
Antisocial or Conduct Disorder					
Nervous Breakdown					
Psychiatric Hospitalization					
Treatment of a psychiatric illness. With medications?					
Suicide or suicide attempts					
Violence or assaultive behavior					
other					

Are there any other behavioral, emotional or learning problems that run in your family?
Please describe:

_____

_____