

ADOLESCENT HISTORY FORM

PARENT VERISON

Instructions: The following form is to assist me in gaining information about your adolescent's early history and current reason for seeking help. Answer all questions to the best of your ability. It is often helpful to obtain the help of other family members who many have better recall of events. Don't worry about spelling or neatness; brief, telegraphic sentences or phrases are fine.

Last Name: _____ First Name: _____ Middle Initial: _____

Today's Date: ____ / ____ / ____ Birth Date: ____ / ____ / ____ Age: _____

Completed by _____

Employment

Please describe the nature of your adolescent's current employment, including any work related problems:

What past jobs has your adolescent had? Indicate any problems he/she may have with them:

Job (Dates)	Problems
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	<hr/>
	<hr/>
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Medical History

Describe any serious illnesses, accidents, diseases or medical conditions of which you are aware.

Any history of chest pain, palpitations, murmurs, fainting, or postexercise symptoms? Describe.

Any family history of early heart disease (before age 30)?

Current Medications

List any medications you are currently taking, with the dosages. Include both prescription and nonprescription medications.

Name of Medication	Why Taken

Past Medications

List all psychiatric or neurological medications taken in the past.

Name of Medication	Why Taken	Why Stopped	When Taken

Does your adolescent smoke? _____ If Yes, how much? _____ Packs per day

Do you think your adolescent had a drinking problem in the past?

Do you think your adolescent has a drinking problem now?

On average, how often does your adolescent drink alcohol? ___Seldom or never ___ Once a month
___Once a week or less ___2-3 times per week ___4 or more times per week

If your adolescent drinks alcohol, how much do they usually consume at one time?

- ___ An ounce or less of liquor or one beer
- ___ 2-4 ounce of liquor or 2 to 4 beers
- ___ more than 4 ounces of liquor or more than 4 beers

Does your adolescent have a problem with dependence on drugs? If Yes, describe.

Has your adolescent had a drug problem in the past? If Yes, describe.

Please note any other information about your adolescent and your family that you think might be helpful in understanding their problems.



