Beautiful Minds
MEDICAL, INC.

Child Personal History

(17 and younger)

Patient Name: _____ **DOB:** _____ **Date:** _____

To be completed by parent or guardian. The information you provide to us will be very helpful in treating your child. Please fill out completely. If you have any difficulty, complete as much as possible. Thank you!

Today's Date: _____ Your Name: _____

Child's Name: _____ Age: _____

Reason for seeking help? _____

_____

_____

Please review the following list and CIRCLE the ones that you feel fit your child:

1. Speech difficulties
2. Nervous habits/behavior
3. Frequent headaches
4. Frequent stomach-aches
5. Difficulty sleeping
6. Lacks guilt/remorse
7. Difficulty making friends
8. Difficulty keeping friends
9. Little interest in friends
10. Little interest in activities
11. Disrespectful/argumentative
12. Doesn't complete schoolwork
13. Acts before thinking
14. Short attention-span
15. Unable to sit still
16. Overactive
17. Underactive
18. Sucks thumb
19. Bangs head
20. Grinds teeth
21. Nightmares
22. Seems angry
23. Hurts animals
24. Sets fires
25. Steals
26. Lies a lot
27. Too serious
28. Fights a lot
29. Clowns a lot
30. Acts spoiled
31. Temper tantrums
32. In own world
33. Afraid/fearful
34. Accident-prone
35. Seems insecure
36. Sad/depressed
37. Worries a lot
38. Cries frequently
39. Mentally slow
40. Interested in sex
41. Looks "high" often
42. Separation problems
43. Imaginary friends
44. Ignores rules
45. Defies authority

Ethnicity (circle which one applies): Hispanic or Latin OR Not Hispanic or Latin

Hawaiian or Latin

Race (circle which ones apply):

Asian Native Hawaiian Other Pacific Island Black or African American

White Hispanic Other Pacific Islander Other Race

Does your child have any medical problems? If so, please list _____

_____

_____

_____

Any surgeries?_____

_____

Please list any allergies: _____

_____

Please list all medications the child is currently taking:

Medication	Dosage	Directions	Reason for taking