**Child/Adolescent Social and Health History**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client Name** (First, MI, Last) | | | **Date of Birth** | | **Today’s Date** |
| **Presenting Problem** | | | | | |
| Why are you seeking treatment today? | | | | | |
| How long ago did you begin to be troubled by this problem? | | | | | |
| How often do you experience this problem? | | | | | |
| When did you first consult a professional (counselor, physician, social worker, etc.)? | | | | | |
| **Symptom Checklist**  Check All Current Problems | | | | | |
| **Nutritional/Eating Pattern Changes/Disorders** | | | | | |
|  | As evidenced by:  Self-induced Vomiting  Binge Eating  Use of Laxatives | Increase in Appetite  Decrease in Appetite  Excessive Exercising | | Weight Gain  Weight Loss  None | |
| **Pain Management** | | | | | |
|  | As evidenced by:  Pain Interferes with Activities | None | |  | |
| **Depressed Mood/Sad** | | | | | |
|  | As evidenced by:  Loss of Interest in Activities  Empty Feeling  Fatigue/Loss of Energy  Thoughts of Harming Yourself | Hopelessness  Worthlessness  Trouble Concentrating  None | | Indecisiveness  Recurrent Thoughts of Death  Feeling Sad or Depressed | |
| **Grief Issues** | | | | | |
|  | As evidenced by:  Loss of Loved One in Past Year | Other Loss (Describe) | | None | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Client Name** (First, MI, Last) | | | **Date of Birth** |
| **Anxiety** | | | |
|  | As evidenced by:  Excessive Worry  Restlessness  Obsessions  Muscle Tension  None | Irritability  Compulsions  Difficulty Breathing  Pounding Heart | Excessive Checking  Strong Fears  Shaking  Excessive Handwashing |
| **Traumatic Stress** | | | |
|  | As evidenced by:  Recurrent/Intrusive/Distressing Thoughts/Images  Recurrent Dreams/Nightmares | Startles Easily  Exposure to Traumatic Event | None |
| **Anger/Aggression** | | | |
|  | As evidenced by:  Threatens/Intimidates Others  Initiates Fights | Physically Hurts People  Physically Hurts Animals | Use of Weapons  None |
| **Oppositional Behaviors** | | | |
|  | As evidenced by:  Loses Temper  Argues  Deliberately Annoys Others | Blames Others  Easily Annoyed  Angry and Resentful | Spiteful/Vindictive  None |
| **Inattention** | | | |
|  | As evidenced by:  Difficulty Sustaining Attention  Trouble Finishing Things | Disorganized  Easily Distracted | Forgetful  None |
| **Impulsivity** | | | |
|  | As evidenced by:  Difficulty Resisting Impulses  None | Trouble Waiting for Turn | Frequently Interrupts |
| **Disturbed Reality Contact** | | | |
|  | As evidenced by:  Hears Voices Others Don’t Hear | Seeing Things Others Don’t See | None |
| **Mood Swings/Hyperactivity** | | | |
|  | As evidenced by:  Excessive Movement  Decreased Need for Sleep  None | Excessive Talking  Irritability | Rapid or Extreme Changes in Mood  Inflated Self-Esteem |
| **Addictive Behaviors** | | | |
|  | As evidenced by:  Gambling  Pornography | Internet  None | Shopping |

|  |  |  |  |
| --- | --- | --- | --- |
| **Client Name** (First, MI, Last) | | | **Date of Birth** |
| **Sleep Problems** | | | |
|  | As evidenced by:  Difficulty Falling or Staying Asleep  Excessive Sleepiness | Sleepwalking  None | Frequent Nightmares |
| **Wetting or Soiling** | | | |
|  | As evidenced by:  Daytime | Nighttime | None |
| **Sexual Orientation and/or Gender Expression**  Heterosexual  Homosexual  Bisexual  Transgender  Questioning Other relevant information: | | | |
| **Stressors** | | | |
|  | | | |
| **Other** | | | |
|  | As evidenced by:  Obsessions | Compulsions | Other: |
| **Pertinent Developmental Issues**  **(Include motor development and functioning)** | | | |
| **Mother’s Pregnancy History** (include prenatal exposure to alcohol, tobacco, and other drugs) | | | |
|  | No Problems Reported | | |
| **Infancy (Ages 0-1)** | | | |
|  | No Problems Reported | | |
| **Preschool (Ages 2-4)** | | | |
|  | No Problems Reported | | |
| **Childhood (Ages 5-12)** | | | |
|  | No Problems Reported | | |
| **Adolescent (Ages 13-17)** | | | |
|  | No Problems Reported | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Name** (First, MI, Last) | | | | | | **Date of Birth** | |
| **Living Situation** | | | | | | | |
| **Parent’s Home**  Rent Own | | **\*\*Residential Care/Treatment Facility**  Hospital Temporary Housing Residential Care Nursing Home | | | | | |
| **\*\*Other**  Friend’s Home Relative’s/Guardian’s Home Foster Care Home Respite Care  Homeless Living with Friend Homeless in Shelter/No Residence Jail/Prison Other: | | | | | | | |
| **\*\*Identify Facility or Person’s Name** | | | | | | | |
| **Primary Household** | | | | | | | |
| Household Member Names | Relationship  To Client | | Age | Occupation/School | Level of  Education | | Quality of Relationship (Staff Use Only) |
|  |  | |  |  |  | |  |
|  |  | |  |  |  | |  |
|  |  | |  |  |  | |  |
|  |  | |  |  |  | |  |
|  |  | |  |  |  | |  |
|  |  | |  |  |  | |  |
| **Secondary Household** | | | | | | | |
| **Does client live in more than one household?**  No If no, skip to “Additional Family Members”  Yes If yes, complete the secondary household information below | | | | | | | |
| Household Member Names | Relationship  To Client | | Age | Occupation/School | Level of  Education | | Quality of Relationship (Staff Use Only) |
|  |  | |  |  |  | |  |
|  |  | |  |  |  | |  |
|  |  | |  |  |  | |  |
|  |  | |  |  |  | |  |
|  |  | |  |  |  | |  |
|  |  | |  |  |  | |  |
| **Secondary Household Street Address** (if different from client’s address listed on Demographic Information Form) | | | | | | | |
| **Family Members Who Live in Both Households**  Client only Client and (List): | | | | | | | |
| **Additional Family Members** (i.e., parents or siblings not living in primary or secondary households)  No parents or siblings other than those listed in primary or secondary households | | | | | | | |
| **Custody and Parenting Plan**  Lives with both parents (biological or adoptive) in same household or with widowed parent  Other (describe): | | | | | | | |

|  |  |  |
| --- | --- | --- |
| **Client Name** (First, MI, Last) | | **Date of Birth** |
| **Family Environment/Relationships** | | |
| **Parent-Child (Client) Relationship(s):** Not Applicable P = Primary Household S = Secondary Household B = Both | | |
| **Comment on Parent-Child Relationship(s):** (could include parent-child conflict, parent supervision and monitoring of child, cooperation between parents regarding child rearing, parent positive activities with child, parent satisfaction with relationship, child satisfaction with relationship(s)) | | |
| **Sibling-Child (Client) Relationship(s):** No Siblings P = Primary Household S = Secondary Household B = Both | | |
| **Comment on Sibling-Child Relationship(s):** (could include sibling-child conflict, positive activities with child, sibling satisfaction with relationship, child satisfaction with relationship(s)) | | |
| **Parent Marital or Couples Relationship(s):** Not Applicable at this time P = Primary Household S = Secondary Household B = Both | | |
| **Comment on Parent Marital or Couples Relationship(s):** (could include marital or couples conflict, marital or couples satisfaction with relationship(s)) | | |
| **Family Concerns** | | |
|  | **If yes, indicate relationship to child:** | |
| Family Member Alcohol Abuse: No Yes |  | |
| Family Member Drug Abuse: No Yes |  | |
| Family Member Mental Health Problems: No Yes |  | |
| Family Member Health Problems: No Yes |  | |
| Family Member Disability: No Yes |  | |
| Family Member Legal Issues: No Yes |  | |
| Family Member Financial Concerns No Yes |  | |
|  | | |
| **Other** (describe) | | |
| **Comment on other family concerns and information relating to financial status** (specify problems that impact client’s needs) | | |

|  |  |  |
| --- | --- | --- |
| **Client Name** (First, MI, Last) | | **Date of Birth** |
| **School Functioning** | | |
| **Educational Classification** | | |
| Name of School: | | Current Grade: |
| Regular Education Classification, No Special Services  Yes No If no, check all that apply  01 Multiple disabilities (not deaf-blind) 06 Orthopedic Impairment 11 Autism  02 Deaf-Blindness 07 Emotional Disturbance (SBH) 12 Traumatic Brain Injury  03 Deafness (hearing impairment) 08 Developmental Disability 13 Other Health Impaired (Major)  04 Visual Impairment 09 Specific Learning Disability 14 Other Health Impaired (Minor)  05 Speech or Language Impairment 10 Preschoolers with a Disability 15 Current 504 Plan  Other: | | |
| **Comments on Educational Classification/Placement** (please indicate if client is home schooled, in gifted program, etc.) | | |
| **Grades** | | |
| **School Proficiency/Achievement Exams/Ohio Graduation Tests (OGT)**  **Most Recent Exams:** Grade level taken       OGT (reading and math only) Has not taken these exams | | |
| **Exams Taken** | **Results** | |
| **Reading** | Passed Did Not Pass Unknown | |
| **Math** | Passed Did Not Pass Unknown | |
| **Citizenship** | Passed Did Not Pass Unknown or N/A | |
| **Science** | Passed Did Not Pass Unknown or N/A | |
| **Writing** | Passed Did Not Pass Unknown or N/A | |
| **Other Test Results** (IQ, Achievement, Developmental)  No other test results reported | | |
| **Attendance**  Not a problem | | |
| **Previous Grade Retentions**  None reported | | |

|  |  |
| --- | --- |
| **Client Name** (First, MI, Last) | **Date of Birth** |
| **Suspensions/Expulsions**  None reported | |
| **Other Academic School Concerns** (including performance/behavioral problems due to AOD use)  None reported | |
| **Barriers to Learning**  None reported Inability to Read or Write Other: | |
| **Peer Relationships/Social Functioning** | |
| **Special Communication Needs**  None reported TDD/TTY Device Sign Language Interpreter Assistive Technology  Language Interpreter Services Needed/Other Spoken Language:  Other: | |
| **Employment** | |
| Not Pertinent – Skip this section | |
| **Currently Employed?** Yes No If yes, name of employer | |
| Name of Employer:       Job Title: | |
| **Employment Interests/Skills/Concerns** | |

|  |  |  |
| --- | --- | --- |
| **Client Name** (First, MI, Last) | | **Date of Birth** |
| **Legal History** | | |
| **Current Legal Status**  None Reported On Probation Detention On Parole  AoD Related Legal Problems Awaiting Charge Court Ordered to Treatment Others | | |
| **History of Legal Charges**  No Yes If yes, check and describe | Status Offense (e.g., Unruly)  Delinquency | |
| **Name of Probation/Parole Officer** (if applicable) | | |
| **Adjudications**  No Yes If yes, describe: | | |
| **Detentions or Incarcerations**  No Yes If yes, describe: | | |
| **Civil Proceedings**  No Yes If yes, describe: | | |
| **Domestic Relations Court Involvement**  No Yes If yes, describe: | | |
| **Juvenile Court Involvement (**related to child abuse, neglect, or dependency)  Current: No Yes Comment:  Past: No Yes Comment: | | **Caseworker Name** (if applicable) |
| **Children’s Protective Services Involvement with Family**  No Yes If yes, describe: | | |
| **Name of Children’s Protective Services Caseworker(s) Assigned to Family** (if applicable)  None Reported | | |
| **Name of Guardian ad Litem (GAL) or Court Appointed Special Advocate (CASA) Assigned to Family** (if applicable)  None Reported | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Client Name** (First, MI, Last) | | | | **Staff Use Only: Client Number** | | **Date of Birth** |
| **Child/Adolescent Health History Questionnaire**  This form should be completed as fully as possible by client, but reviewed by medical or clinical staff | | | | | | |
| Has the child had any of the following health problems? | | | | | | |
|  | Now | Past | Never | | What Treatment Was Received and Date(s) | |
| Anemia |  |  |  | |  | |
| Arthritis |  |  |  | |  | |
| Asthma |  |  |  | |  | |
| Bleeding Disorder |  |  |  | |  | |
| Blood Pressure (high or low) |  |  |  | |  | |
| Bone/Joint Problems |  |  |  | |  | |
| Cancer |  |  |  | |  | |
| Cirrhosis/Liver Disease |  |  |  | |  | |
| Diabetes |  |  |  | |  | |
| Epilepsy/Seizures |  |  |  | |  | |
| Eye Disease/Blindness |  |  |  | |  | |
| Fibromyalgia/Muscle Pain |  |  |  | |  | |
| Glaucoma |  |  |  | |  | |
| Headaches |  |  |  | |  | |
| Head Injury/Brain Tumor |  |  |  | |  | |
| Hearing Problems/Deafness |  |  |  | |  | |
| Heart Disease |  |  |  | |  | |
| Hepatitis/Jaundice |  |  |  | |  | |
| Kidney Disease |  |  |  | |  | |
| Lung Disease |  |  |  | |  | |
| Menstrual Pain |  |  |  | |  | |
| Oral Health/Dental |  |  |  | |  | |
| Stomach/Bowel Problems |  |  |  | |  | |
| Stroke |  |  |  | |  | |
| Thyroid |  |  |  | |  | |
| Tuberculosis |  |  |  | |  | |
| AIDS/HIV |  |  |  | |  | |
| Sexually Transmitted Disease |  |  |  | |  | |
| Learning Problems |  |  |  | |  | |
| Speech Problems |  |  |  | |  | |
| Anxiety |  |  |  | |  | |
| Bipolar Disorder |  |  |  | |  | |
| Depression |  |  |  | |  | |
| Eating Disorder |  |  |  | |  | |
| Hyperactivity/ADD |  |  |  | |  | |
| Schizophrenia |  |  |  | |  | |
| Sexual Problems |  |  |  | |  | |
| Sleep Disorder |  |  |  | |  | |
| Suicide Attempts/Thoughts |  |  |  | |  | |
| Dementia |  |  |  | |  | |
| Obesity |  |  |  | |  | |
| Other: |  |  |  | |  | |
| **Please note family history of any of the above conditions and client’s relationship to that family member** | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client Name** (First, MI, Last) | | | | **Date of Birth** | |
| **Current Medication Information**  (medical and psychiatric prescription/OTC/herbal) | | | | | |
| None Reported | | | | | |
| **Medication** | **Rationale** | **Dosage/Route/Frequency** | | | **How is it Working?** |
|  |  |  | | |  |
|  |  |  | | |  |
|  |  |  | | |  |
|  |  |  | | |  |
|  |  |  | | |  |
|  |  |  | | |  |
| **Primary Care Physician** (name, phone no., and address)    **Date of Last Physical Exam** | | | | | |
| **Other Prescribing Physician(s)** (name, phone no., and address) | | | | | |
| **Past Psychiatric Medications** | | | | | |
| None Reported | | | | | |
| **Past Psychiatric Medications** | | **How did it work/Reason for Stopping/Adverse Reactions** | | | |
|  | |  | | | |
|  | |  | | | |
|  | |  | | | |
|  | |  | | | |
|  | |  | | | |
| **Has the child had medical hospitalization/surgical procedures in the last 3 years?**  No Yes If yes, complete information below | | | | | |  |  | **Reason** |
| **Hospital** | **City** | **Date** |  | | |
|  |  |  |  | | |
|  |  |  |  | | |
|  |  |  |  | | |
|  |  |  |  | | |
| **Allergies/Drug Sensitivities or Adverse Reactions**  None  Food (specify)  Medicine (specify)  Other (specify) | | | | | |
| **Pregnancy History** Not Pertinent | | | | | |
| **Currently Pregnant?** (If yes, expected delivery date)  No Yes Expected Delivery Date | | **Receiving Prenatal Healthcare?** (If yes, indicate provider)  No Yes Provider | | | |
| **Currently Breastfeeding?** No Yes | | | | | |
| **Last Menstrual Period Date** | |  | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Name** (First, MI, Last) | | | | | | | | | **Date of Birth** | | | |
| **Medical Information** | | | | | | | | | | | | |
| **Indicate how many times in the past 12 months the child has used these medical services:**  Hospital admissions Emergency room visits  Regular visits to doctor Regular visits to dentist | | | | | | | | | | | | |
| **Has the child had any of the following symptoms in the past 60 days?** (please check all that apply) | | | | | | | | | | | | |
| Ankle Swelling | | | | Diarrhea | | | Nervousness | | | | Tingling in Arms and/or Legs | |
| Bed wetting | | | | Dizziness | | | Nosebleeds | | | | Tremor | |
| Blood in Stool | | | | Falling | | | Numbness | | | | Urination Difficulty | |
| Breathing Difficulty | | | | Gait Unsteadiness | | | Panic Attacks | | | | Vaginal Discharge | |
| Chest Pain | | | | Hair Change | | | Penile Discharge | | | | Vision Changes | |
| Confusion | | | | Hearing Loss | | | Pulse Irregularity | | | | Vomiting | |
| Consciousness Loss | | | | Lightheadedness | | | Seizures | | | | Other: | |
| Constipation | | | | Memory Problems | | | Shakiness | | | |  | |
| Coughing | | | | Mole/Wart Changes | | | Sleep Problems | | | | Other: | |
| Cramps | | | | Muscle Weakness | | | Sweats (night) | | | |  | |
| **Immunizations – Has the child had or been immunized for the following diseases?** (please check all that apply) | | | | | | | | | | | | |
| Chicken Pox  Mumps | | | Diphtheria  Polio | | | German Measles  Small Pox | | Hepatitis B  Tetanus | | | | Measles  Other: |
| **Immunizations Within the Past Year** | | | | | | | | | | | | |
| **Height** | | **Has client’s weight changed in the past year?**  No Yes If yes, by how much (+ or -): | | | | | | | | | | |
| **Weight** | |
| **Do you use any complementary health approaches with your child (i.e.: meditation, yoga, nutrition, etc.)?** | | | | | | | | | | | | |
| **Nutritional Screening** | | | | | | | | | | | | |
| **No Problem** | **Eating**  More Less Not Eating | | | | **Drinking**  More Less Takes Liquids Only | | | | | **Appetite**  Increased Decreased | | |
| Nausea Vomiting Trouble Chewing or Swallowing | | | | | | | | | | | | |
| **Special Diet** | | | | | | | **Other** | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Client Name** (First, MI, Last) | | | | | **Date of Birth** | |
| **Pain Screening** | | | | | | |
| **Does pain currently interfere with the child’s activities?** (if yes, how much does it interfere with these activities [please check])  No Yes Not at all Mildly Moderately Severely Extremely | | | | | | |
| **Please indicate the source of the pain** | | | | | | |
| **Substance Use History/Current Use**  (Please check and complete appropriate columns) | | | | | | |
| **Which of the following has the child used?** | **Age first used** | | **Age last used** | **Frequency of use** | | |
| Beer |  | |  |  | | |
| Wine |  | |  |  | | |
| Liquor |  | |  |  | | |
| Heroin |  | |  |  | | |
| Barbiturates |  | |  |  | | |
| Amphetamines |  | |  |  | | |
| Crack |  | |  |  | | |
| Cocaine |  | |  |  | | |
| Marijuana/Hashish |  | |  |  | | |
| LSD |  | |  |  | | |
| Inhalants |  | |  |  | | |
| PCP |  | |  |  | | |
| MDMA (XTC) |  | |  |  | | |
| Prescription drugs off the street |  | |  |  | | |
| Non-prescription drugs by injection |  | |  |  | | |
| Other |  | |  |  | | |
| **Caffeine** | | | **Tobacco** | | | |
| Cups of caffeinated coffee per day | | | Packs of cigarettes per day | | | |
| Cups of caffeinated tea per day | | | Other nicotine products per day | | | |
| Cups of caffeinated soft drinks per day | | | Vaping/e-cigarettes | | | |
| Ounces of chocolate per day | | | Other Use: | | | |
| **Print Name of Person Completing This Questionnaire** | | **Signature of Person Completing This Questionnaire** | | | | **Date** |
| **Clinician Reviewer Comments, Recommendations or Referrals**      **Recommendations shared with client?**  No Yes If yes, client’s response:  **If no, how will recommendations be shared with client?** | | | | | | |
| **Print Name of Clinician** | | **Signature of Clinician** | | | | **Date** |