Shorehaven Behavioral Health, Inc. - Child History

Child's Name:_____ Date:____/____/____ Therapist:_____

Instructions: Your therapist would like an adult in the family to answer these questions. This will help us better understand your child's or adolescent's situation and problem.

Names of all who reside in household:_____

_____

In case of an emergency, name and telephone number of your nearest relative:

_____ Telephone:_____

Who referred you?/How did you hear about us?_____

PSYCHOLOGICAL HISTORY

A. What problem(s) caused you to seek help for your child?_____

_____

B. Check if your child or adolescent have had any of these problems or symptoms recently:

___ Anxiety	___ Changes or problems in eating	___ Drug abuse	___ Defiant
___ Tearfulness/crying	___ Changes or problems in sleeping	___ Headaches	___ Panic
___ Nervousness	___ Stomach aches	___ Irritable	___ Lying
___ Depression	___ Difficulty concentrating	___ Bed-wetting	___ Sadness
___ Truancy	___ Lost interest in activities	___ Impulsive	___ Running away
___ Dizziness	___ Fatigue/tiredness	___ Nightmares	___ Easily distracted
___ Restless, fidgety	___ Change in friends	___ Stealing	___ Tantrums
___ Arguing with adults	___ Excessive worry	___ Disruptive in school	

___ Other: _____

___ Fears (circle): dying going crazy crowds dark animals other:_____

C. Have there been any recent **illnesses or deaths** among your family or close friends? ___ Yes ___ No

D. Have there been any recent **crises** or **major changes** in your life? ___ Yes ___ No

E. Has your child ever experienced any emotional, physical, or sexual **abuse**? ___ Yes ___ No

F. Has your child ever intentionally hurt himself or herself or made a **suicide attempt**? ___ Yes ___ No

G. Has your child taken **medications** for anxiety, depression, sleep, emotional conditions? ___ Yes ___ No

List them:

H. Has anyone in your family been in counseling or psychotherapy or had treatment from a psychiatrist before?

When and with whom:

I. Has anyone in your family had any hospitalization(s) for emotional problems? ___ Yes ___ No

When and where:

J. Please name any people or organizations that provide help and support to your family:_____

_____

MEDICAL HISTORY

A. List any current medical conditions and disabilities of the child:_____

_____

B. Is your child taking any medications? ___ Yes ___ No List them:

C. List past medical conditions (include any surgeries):_____

_____

D. Name of your physician(s) and their telephone number(s) and address(es): _____

_____

E. Has your child had a medical exam within the past year? ___ Yes ___ No

Findings:

F. Indicate anyone in the family who has had these problems:

Problem Who	Problem Who	Problem Who
Allergies to Medications:	Diabetes_____	Seizures_____
	Emphysema_____	Sexual difficulties_____
Allergies_____	Eye/ear/vision_____	Sexually transmitted disease_____
Anemia_____	Fatigue_____	Skin problems_____
Arthritis_____	Head injuries_____	Speech/language_____
Asthma_____	Headaches_____	Thyroid_____
Back problems_____	Heart problems_____	Other (e.g. genetic):
Bowel problems_____	Kidney problems_____	
Cancer_____	Liver problems_____	Any *Disabilities*_____
High blood pressure_____	Neurological problem_____	
Chronic pain_____	OB/GYN problems_____	***Please complete the 2nd page-***
Constipation_____	PMS_____	

DRUG AND ALCOHOL USE

A. Please describe the drug and alcohol use of your family. Whether substances are used by the youth or parents or siblings, chemical use in the family often has a profound influence on child development. Use the number which best states how often each person uses each drug.

0 = Never or less than once a month, 2 =weekends only, 3 = up to 10 days a month 4 = 11-20 days a month, 5= daily or almost daily, 6 = used in past, not using now. If you view this pattern as a problem, *circle the number.*

Who	Beer/Wine/ Liquor	Nicotine	Marijuana	Crack/ Cocaine	Inhalants/ Huffing	Speed/Ecstacy/ Amphetamines	Opiates/Pain meds/Oxy/Vicodin/ Downers	LSD, over-the-counter meds, others
Child-client								
Mother								
Father								
Step-parent								
Sibling								
Other: Who? _____								

B. Are you **concerned** about your child or adolescent's drug or alcohol use? ___ Yes ___ No
C. Does he or she get angry when others criticize the use of drugs or alcohol? ___ Yes ___ No
D. Are you concerned about the drug or alcohol use of someone else in your family? ___ Yes ___ No
E. Did your child grow up in a home at a time when a parent abused drugs or alcohol? ___ Yes ___ No
F. Did you grow up in a home in which a parent abused drugs or alcohol? ___ Yes ___ No
G. Age at child's first drink? _____ Age of first use of other drugs?_____

LEGAL PROBLEMS

A. Has your child or adolescent ever been arrested (including OWI/DUI)? ___ Yes ___ No
B. Have you ever been involved with Protective Services? ___ Yes ___ No
C. Please list other legal problems:

SCHOOL AND WORK HISTORY

A. Is your child or adolescent currently enrolled in school? ___ Yes ___ No
B. Highest grade completed? _____
C. Describe child's usual performance in school? Has it changed? _____
D. Occupation(s) of child's parent(s):_____

What strengths and good behaviors does your child have which will enable him or her to help resolve problems:

What experiences, needs, or difficulties does your child have which do or may pose challenges?

What family and community supports and resources are available to your child to help him or her?

Please tell us about any lifestyle or family values, including religious values, which affect your child positively or negatively or which we should know about?

Lastly, please tell us about your child's recovery? For instance, What would you like to see happen? What are the priorities for changes? What are the recovery goals?