Adult & Child– YOUTH FORM
CONFIDENTIAL CLINICAL HISTORY

Name: **Client #:**

Please provide the following information. It will allow your therapist to begin to understand your child while he/she listens to your current concerns.

Over the past 2 weeks, how often has your child had problems in the following areas?	Never or NA	Sometimes	Frequently	Nearly Always
EDUCATION				
My child has school attendance problems:	☐	☐	☐	☐
My child gets into fights or arguments at school:	☐	☐	☐	☐
My child has difficulty obeying school rules:	☐	☐	☐	☐
My child is easily distracted and hyper in the classroom:	☐	☐	☐	☐
My child gets poor grades in school:	☐	☐	☐	☐
HOME				
My child leaves the home without permission:	☐	☐	☐	☐
My child is frequently angry or argumentative with family members:	☐	☐	☐	☐
My child demands frequent attention:	☐	☐	☐	☐
My child has poor attention or high activity in the home:	☐	☐	☐	☐
My child has problems with bedwetting or soiling his/her pants:	☐	☐	☐	☐
COMMUNITY				
My child engages in illegal behavior (e.g., shoplifting, property damage):	☐	☐	☐	☐
I have concerns about my child's betting/gambling behavior.	☐	☐	☐	☐
I or others have concerns about my child's sexual behaviors:	☐	☐	☐	☐
My child has no positive relationships with others outside of the family:	☐	☐	☐	☐
My child bullies others, is mean towards animals, or starts frequent fires.	☐	☐	☐	☐

Over the past 2 weeks, how often has your child had problems in the following areas?	Never or NA	Sometimes	Frequently	Nearly Always
EMOTIONS/THINKING CONCERNS				
My child frequently feels sad or discouraged:	☐	☐	☐	☐
My child suffers from excessive worry:	☐	☐	☐	☐
My child has difficulty sleeping:	☐	☐	☐	☐
I have concerns about my child's eating behaviors:	☐	☐	☐	☐
My child has fears that keep him/her from doing normal things:	☐	☐	☐	☐
My child is easily angered.	☐	☐	☐	☐
My child has difficulty communicating his/her thoughts clearly:	☐	☐	☐	☐
My child sees or hear things that are not there:	☐	☐	☐	☐
SELF-HARM				
My child talks about suicide or hurting him/herself:	☐	☐	☐	☐
My child hurts him/herself on purpose:	☐	☐	☐	☐
FAMILY				
Other family members have mental health and/or substance abuse issues:	☐	☐	☐	☐
I find myself feeling angry or frustrated toward my child:	☐	☐	☐	☐
I have concerns about providing food, clothing, or shelter for my child:	☐	☐	☐	☐
There is frequent conflict around custody, visitation, or other divorce-related issues:	☐	☐	☐	☐
I have difficulty setting limits and disciplining my child:	☐	☐	☐	☐

CULTURAL AND EDUCATIONAL HISTORY:

Are there any cultural, ethnic, or religious/spiritual issues that your child's therapist should be aware of?

Does your child have a shared religious/spiritual community? Yes ☐ / No ☐

If yes, is the community important to your child? Yes ☐ / Somewhat ☐ / No ☐

If yes, is the community a positive support to your child? Yes ☐ / No ☐

School Performance:
Strong ☐ Fair ☐ Needs Improvement ☐
Preferred School Subject(s):
Learning Attitude: Engaged ☐ Fair ☐ Poor ☐
School Future Plans:

Learning Disability/Difficulties? Yes ☐ / No ☐
Communication Difficulties? Yes ☐ / No ☐
Previous School Testing? Yes ☐ / No ☐
Current School IEP? Yes ☐ / No ☐

Name:	Client #:

DEVELOPMENTAL MILESTONES HISTORY:			
Was the pregnancy and delivery of your child normal?	Y	N	NA
Did your child walk across the room alone by 18 months?	Y	N	NA
Did your child speak in simple sentences by age 3?	Y	N	NA
Does your child maintain friendships with children of the same age easily?	Y	N	NA
Does your child do age appropriate chores regularly?	Y	N	NA
Has your child been identified as having learning disabilities or other developmental delays?	Y	N	NA

History of Substance Use Problems (past 3 years; check any that apply):

☐ **Failed attempts to stop use**	☐ **Memory blackouts**	☐ **Loss of consciousness**	☐ **Tremors**
☐ **Morning use**	☐ **Perceptual Disturbance**	☐ **Hallucinations**	☐ **Seizures**
☐ **Guilt due to excessive use**	☐ **Legal problems**	☐ **Incarceration**	☐ **Financial problems**
☐ **Criticism by others over use**	☐ **Missed work**	☐ **Medical problems**	☐ **Physical injury**
☐ **Home responsibilities problems**	☐ **Arguments or fights**	☐ **Shared needle use**	☐ **Problems with family/friends**

SUBSTANCE USE HISTORY: N/A ☐

Substance:	How Taken:	How Often:	Age First Used:	Date Last Used:

Has your child ever had difficulty with alcohol or other drugs?	Y	N
Does anyone in the family currently have difficulty with alcohol or other drugs?	Y	N
Have you ever used drugs using an IV needle?	Y	N
Was the child exposed to any substances in utero?	Y	N

Family Financial Support: Food Stamps: ☐Yes ☐No TANF: ☐Yes ☐No Supportive Housing: ☐Yes ☐No

Race:
- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian
- ☐ Native/Other Pacific Islander
- ☐ Other

Ethnicity:
- ☐ Not Hispanic / Not Latino (White, American Indian, Alaskan Native)
- ☐ Other Hispanic, Latino of Central America, etc.
- ☐ Latino of unknown origin
- ☐ Puerto Rican
- ☐ Mexican
- ☐ Cuban

Name:	Client #:

Indicate family history of mental health, substance abuse, major medical problems and/or learning disabilities: N/A ☐

Family Member Name	Relationship	Problem	Was Treated		Psychiatric Hospitalization	
			Yes	No	Yes	No
			Y	N	Y	N
			Y	N	Y	N
			Y	N	Y	N

MEDICAL HISTORY:

How would you describe your child's overall physical health currently (e.g., excellent, good, fair, poor)?

Please list any allergies your child may have:	Weight:
	Height:

If female, is your child pregnant? Yes ☐ / No ☐ If yes, who is the prenatal care provider? If female, is your child breastfeeding? Yes ☐ / No ☐

Does your child have health problems in the following areas?	Problem Present? Yes	Problem Present? No	Receiving Treatment? Yes	Receiving Treatment? No/NA
Diabetes	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Cancer/cancer history	☐	☐	☐	☐
Obesity	☐	☐	☐	☐
Emphysema/COPD	☐	☐	☐	☐
Heart problems/cardiovascular disease	☐	☐	☐	☐
Hyperlipidemia/high cholesterol	☐	☐	☐	☐
Smoking/other tobacco related problems	☐	☐	☐	☐
Breathing problems /asthma	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Special nutritional needs	☐	☐	☐	☐
Chronic pain	☐	☐	☐	☐
Migraine headaches	☐	☐	☐	☐
Hearing/vision/speech problems	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Kidney/bladder problems	☐	☐	☐	☐
Liver/gallbladder problems	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐
Epilepsy/seizures/neurological problems	☐	☐	☐	☐
Other, specify:	☐	☐	☐	☐

Has your child had the following examinations in the past year:
Physical exam: Yes ☐ / No ☐ Dental Exam: Yes ☐ / No ☐ Visual Exam: Yes ☐ / No ☐ Hearing Exam: Yes ☐ / No ☐

If your child has not had a physical exam done within the past year, please make an appointment with your medical provider for one. If you need assistance locating a medical provider, make the office staff aware of your need.

Name of doctor:	Year of child's last physical exam:	Doctor's phone #:	**Immunizations Current:**
Name of dentist:	Year of child's last dental exam:	Dentist's phone #:	**Yes ☐ / No ☐**

Child's Medication Name	Dose	Why Medication is Prescribed	Prescribing Provider

History of injuries, hospitalizations, surgeries:

Name:	Client #:

Pain Screen:

Is your child currently having physical pain or discomfort? Yes ☐ / No ☐ If yes, pain location?

Pain Rating: (0=no pain, 10=worst ever) 0 1 2 3 4 5 6 7 8 9 10

When did the pain begin? What helps relieve the pain? What makes the pain worse?

Please check any of the following symptoms your child is experiencing:

☐ Night sweats ☐ Chest pain ☐ Foul appearing sputum
☐ Coughing up blood ☐ Cough that won't go away
☐ Fever/Chills

Has your child:

Ever been diagnosed with Tuberculosis (TB)?	**Yes ☐ / No ☐**
Ever had a positive TB skin test?	**Yes ☐ / No ☐**
Been recently exposed to TB?	**Yes ☐ / No ☐**
Ever had an abnormal chest x-ray?	**Yes ☐ / No ☐**
Ever received treatment for TB?	**Yes ☐ / No ☐**

Nutrition Screen: Please check any of the following that apply:

Does your child:

eat less than 3-4 fruit/vegetable & 2 milk product servings daily?	**Yes ☐ / No ☐**
have a poor appetite?	**Yes ☐ / No ☐**
have food allergies?	**Yes ☐ / No ☐**
been recently experiencing nausea/vomiting?	**Yes ☐ / No ☐**
have constipation?	**Yes ☐ / No ☐**
have diarrhea?	**Yes ☐ / No ☐**
weigh excessively more or less for their height?	**Yes ☐ / No ☐**
breast feed or is your child pregnant?	**Yes ☐ / No ☐**

Minimal Risk = 1-2 Yes Moderate Risk = 3-6 Yes High Risk = 7+ Yes

ABUSE/TRAUMA HISTORY:

(Please check all that apply):

Current Abuse: ☐ NA ☐ Physical ☐ Emotional ☐ Sexual ☐ Neglect

Past Abuse: ☐ NA ☐ Physical ☐ Emotional ☐ Sexual ☐ Neglect

While your child has been growing up:

1. Has a parent or other adult in the household **often** … Sworn at, insulted, put down, or humiliated your child? **Or** Acted in a way that made your child feel afraid that they might be physically hurt?	**Yes ☐ / No ☐**
2. Did a parent or other adult in the household **often** … Push, grab, slap, or throw something at your child? **or** **Ever** hit your child so hard that your child had marks or was injured?	**Yes ☐ / No ☐**
3. Did an adult or person at least 5 years older than your child **ever**… Touch or fondle your child or have your child touch their body in a sexual way? **Or** Try to or actually have oral, anal, or vaginal sex with your child?	**Yes ☐ / No ☐**
4. Does your child **often** feel that … No one in their family loves them or thinks they are important or special? **Or** Their family didn't look out for each other, feel close to each other, or support each other?	**Yes ☐ / No ☐**
5. Has your child **often** felt that … They didn't have enough to eat, had to wear dirty clothes, and had no one to protect them? **Or** Their parents were too drunk or high to take care of them or take them to the doctor if needed?	**Yes ☐ / No ☐**
6. Has your child's parents **ever** separated or divorced?	**Yes ☐ / No ☐**
7. Has your child's mother/father or stepmother/stepfather: **Often** been pushed, grabbed, slapped, or had something thrown at her/him? **Or Sometimes or often** been kicked, bitten, hit with a fist, or hit with something hard? **Or Ever** been repeatedly hit over at least a few minutes or threatened with a gun or knife?	**Yes ☐ / No ☐**
8. Has your child lived with anyone who was a problem drinker or alcoholic or who used street drugs?	**Yes ☐ / No ☐**
9. Has a household member depressed or mentally ill or did a household member attempt suicide?	**Yes ☐ / No ☐**
10. Has a household member gone to prison?	**Yes ☐ / No ☐**
Total of "Yes" scores:	_____

Name:	Client #:

DCS/CPS Involvement:

If Abuse/Neglect was reported in Trauma History (above), has this abuse/neglect been reported to DCS/CPS? ☐ Yes ☐ No

Is the child/family currently involved with DCS/CPS? ☐ Yes ☐ No

If yes, Who is the current caseworker? _____

If yes, Which county? _____

Has the child/family been involved with DCS/CPS in the past? ☐ Yes ☐ No

If yes, When? _____

If yes, Which county? _____

If yes, Describe the involvement:

Note: If youth client is a ward of state through Department of Children's Services, please provide the below information regarding any biological parents and siblings:

Name	Age	Relationship	Address	Marital Status

CLIENT/CAREGIVER SIGNATURE:

I verify that I have answered the above questions to the best of my ability and knowledge:

Client Signature Date	If applicable, Guardian Signature Date

HISTORY REVIEW:

Clinician comments:

Clinician Signature Date	Registrar Signature Date