ADULT & CHILD HEALTH

YOUTH- CONFIDENTIAL CLINICAL HISTORY

Name: Patient ID #:

CHILD FULL NAME: **DATE OF BIRTH:** **TODAY'S DATE:**

Mailing Address: City: State/Zip:

Social Security Number: Phone: Age:
Email:

Mother's Name: Father's Name:

Members of Child's Current Household:

Is the Child in Foster Care? ☐ Yes ☐ No Name of foster parent:_____
Is the child a ward of the State? ☐ Yes ☐ No Name of Case Manager: _____

Language Preference:
☐ English ☐ Spanish ☐ Other: _____

Fluent in English: ☐ Yes ☐ No

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

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

Impairments/Disabilities:
☐ Learning or Reading Disability
☐ Communication Difficulties
☐ Intellectual / Developmental Disabilities
☐ Heard of Hearing
☐ Deaf
☐ Blind
☐ Neurological Impairment
☐ Non-ambulatory
☐ Traumatic Brain Injury
☐ Other Physical / Medical
☐ Previous School Testing
☐ Current School IEP

Biological (at Birth) Sex:
☐ Female ☐ Male

Sexual Orientation:
☐ Lesbian, gay, homosexual
☐ Straight of heterosexual
☐ Bisexual
☐ Don't know
☐ Choose not to disclose

Gender Identity:
☐ Identifies as Male
☐ Identifies as Female
☐ Transgender Male/Female-to-Male
☐ Transgender Female/ Male-to-Female
☐ Gender non-conforming
(neither exclusively male nor female)
☐ Choose not to disclose
☐ Additional gender category/
Other:_____

Child's School: _____
Child's Grade: _____

School Performance:
☐ Strong
☐ Fair
☐ Need Improvement
Preferred School Subjects: _____

Child's Strengths: _____
_____

Child's Hobbies: _____
_____

Tobacco Use & Smoking:
☐ Never Smoker
☐ Light Everyday Smoker
☐ Everyday Smoker
☐ Heavy Everyday Smoker
☐ Smokeless Tobacco (vaping, e-cigarettes, chew)
☐ Former Smoker

Family Financial Support:
☐ Food Stamps ☐ TANF

Home Status:
☐ Permanent Housing
☐ Living with Others Temporarily (Doubling Up)
☐ Homeless Living in Streets
☐ Homeless Shelter
☐ Transitional Housing
☐ Institutional Housing
☐ Other: _____
How long have you lived in your current housing situation?
☐ Less than 6 months
☐ 6 months – 1 year
☐ 1 year – 2 years
☐ More than 2 years
☐ Other: _____

Probation Involvement:
☐ Yes
☐ No

Child currently employed:
☐ Yes ☐ No
Hours per week: _____
Placement of Employment:
_____

DEVELOPMENTAL MILESTONES HISTORY:

Was the pregnancy and delivery of your child normal? ☐ Yes ☐ No Did your child receive First Steps services? ☐ Yes ☐ No
Did your child walk across the room alone by 18 months? ☐ Yes ☐ No Did your child speak in simple sentences by age 3? ☐ Yes ☐ No
Does your child do age appropriate chores regularly? ☐ Yes ☐ No
Does your child maintain friendships with children of the same age easily? ☐ Yes ☐ No
Has your child been identified as having learning disabilities or other developmental delays? ☐ Yes ☐ No

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Instructions *(for the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

FOR YOUTH AGES 6-17

	During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2. Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3. Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4. Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5. Had less fun doing things then he/she used to?	0	1	2	3	4	
	6. Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7. Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8. Seemed angry or lost her/her temper?	0	1	2	3	4	
VII.	9. Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10. Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11. Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12. Not able to stop worrying?	0	1	2	3	4	
	13. Said he/she couldn't do things he/she wanted to or should have done, because they made him /her feel nervous?	0	1	2	3	4	
IX.	14. Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15. Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16. Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17. Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18. Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19. Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
	In the past **TWO (2) WEEKS,** has your child …						
XI.	20. Had an alcoholic beverage (beer, wine, liquor, etc.)? Had an alcoholic beverage (beer, wine, liquor, etc.)?		☐ Yes	☐ No	☐ Don't Know		
	21. Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?		☐ Yes	☐ No	☐ Don't Know		
	22. Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)? speed)?		☐ Yes	☐ No	☐ Don't Know		
	23. Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?		☐ Yes	☐ No	☐ Don't Know		
XII.	24. In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?		☐ Yes	☐ No	☐ Don't Know		
	25. Has he/she EVER tried to kill himself/herself?		☐ Yes	☐ No	☐ Don't Know		

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SUBSTANCE USE HISTORY: NA ☐	How Taken:	How Often:	Age First Used:	Date Last Used:
☐ Alcohol				
☐ Marijuana				
☐ Methamphetamine				
☐ Crack/Cocaine				
☐ Opiates/Heroin				
☐ Benzodiazepines				
☐ Other:				

Have you ever had difficulty with alcohol or other drugs?	Y	N
Does anyone in your family currently have difficulty with alcohol or other drugs?	Y	N
Have you ever used drugs using an IV needle?	Y	N
Are you pregnant?	Y	N

History of Substance Use Problems (past 12 months; 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

If in recovery, longest period (number of days) of sobriety in past six months: ____
Have you attended AA/NA 12 Step programs before? ☐ Yes ☐ No Number of AA/NA Meetings Attended in the last 30 days:_____

Health & Life Functioning Screen

Do you have an established *Psychiatric Advance Directive* or *Power of Attorney* for your behavioral health care needs? Yes ☐ No ☐

Pain Screen: Are you 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 your pain begin? _____
What helps relieve your pain? _____ What makes your pain worse? _____

Tuberculosis Screen: Please check any of the following symptoms you are experiencing:
☐ Night sweats ☐ Chest pain ☐ Foul appearing sputum
☐ Coughing up blood ☐ Cough that won't go away ☐ Fever/Chills

Have you ever been told you have Tuberculosis (TB)? Yes ☐ No ☐
Have you had a positive TB skin test? Yes ☐ No ☐
Have you recently been exposed to TB? Yes ☐ No ☐
Have you had an abnormal chest x-ray? Yes ☐ No ☐
Have you received treatment for TB? Yes ☐ No ☐

Nutrition Screen: Please check any of the following that apply:
Eat less than 3-4 fruit/vegetable & 2 milk product servings daily? Yes ☐ No ☐
Have a poor appetite, or decreased food intake Yes ☐ No ☐
Have food allergies? Yes ☐ No ☐
Been recently experiencing nausea/vomiting? Yes ☐ No ☐
Have constipation? Yes ☐ No ☐
Have diarrhea? Yes ☐ No ☐
Experienced weight loss or gain of 10 pounds or more in the last 3 months? Yes ☐ No ☐
Experienced bingeing or induced vomiting?

Do you have any gender specific treatment needs that your provider should be aware of? _____
Are there any cultural, ethnic, or religious/spiritual issues that your therapist should be aware of? _____
Do you have a shared religious/spiritual community? ☐ Yes ☐ No
If yes, is your community important to you? ☐ Yes ☐ No ☐ Somewhat If yes, is your community a positive support to you? ☐ Yes ☐ No

Members in Household: Name	Relationship	Age	Occupation

MEDICAL INFORMATION:

Current Medications	Dose	Frequency	Why medication is Prescribed	Prescribing Provider

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Medication/Vaccine Allergies	Reaction (rash, shock, hives, etc.)

Do you have a primary care provider (Family Medicine, Internal Medicine, or Pediatrician)? Yes ☐ No ☐
Name of primary care provider: _____ Phone: _____

Height:

Weight:

Have you had the following examinations in the past year:
Physical Exam: Yes ☐ No ☐ Dental Exam: Yes ☐ No ☐ Visual Exam: Yes ☐ No ☐ Hearing Exam: Yes ☐ No ☐
Does your child receive regular well child care with a primary care physician? Yes ☐ No ☐
Are your child's immunizations up to date? Yes ☐ No ☐

Name of doctor: _____ Year of last physical exam: _____ Doctor's phone #: _____
Name of dentist: _____ Year of last dental exam: _____Dentist's phone #: _____

If Female, are you pregnant? Yes ☐ No ☐ If yes, who is the prenatal care provider?

If you have not had a physical examination done within the past year, please make an appointment with your medical provider. If you need assistance locating a medical provider, make the office staff aware of your need.
Would you like to talk to someone about primary care services at A&C? Yes ☐ No ☐

Medical History	Self	Mother's side	Father's side	Comments
ADD/ADHD				
AIDS/HIV				
Abuse/Domestic Violence				
Allergies/Hayfever				
Alzheimer's Disease				
Anemia				
Anesthesia Complication				
Anxiety Disorder				
Arthritis				
Asthma				
Autism Spectrum Disorder				
Bipolar Disorder				
Bladder or Kidney Problem				
Blood Diseases				
Brain Injury				
Chicken Pox / Shingles				
Constipation				
Depression				
Developmental or Behavioral Disorder				
Dementia				
Depressive Disorder				
Diabetes				
Difficulty Swallowing				
Disorder of the Nervous System				
Ear or Hearing Problems				
Eating Disorder				
Eczema				
Epilepsy				

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Medical History	Self	Mother's side	Father's side	Comments
GERD/Reflux				
GI Problems				
Headaches / Migraines				
Hepatitis				
High Cholesterol				
Kidney Disease/Kidney Stones				
Learning Disorder				
MRSA exposure				
Obesity				
Panic Disorder				
Rheumatic diseases / Autoimmune				
Schizophrenia				
Seizures/Epilepsy				
Sexual Abuse				
Skin Problems				
Sleep Disorder				
Thyroid Disease/Thyroid Problems				
Tourette Syndrome				
Tuberculosis				
Vision or Eye Problems				

Personal Surgical History

Surgery	Yes	No	Dates/ Comments
Adenoid Surgery			
Appendix removed (Appendectomy)			
ENT Surgery / Ear Tubes			
Neurosurgery			
Orthopedic Surgery			
Tonsillectomy			
VP Shunt Placement			
Other:			

Health Habits

Sexual Activity

☐ Sexually Active ☐ Not Currently Sexually Active

Birth Control Method used at present: _____ Have you ever had sex with (circle one)? **Men /Women /Both**

Exercise

☐ Active at least 3 times per week ☐ Active at least 1-2 times per week ☐ Sedentary (very little or no regular activity)

Activities engaged in: _____Barriers to exercise: _____

ABUSE/TRAUMA HISTORY: NA ☐

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

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

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** … Swear at you, insult you, put you down, or humiliate you? **OR** Act in a way that made you afraid that you might be physically hurt?	Yes ☐ No ☐
2. Did a parent or other adult in the household **often** … Push, grab, slap, or throw something at you? **OR** **Ever** hit you so hard that you had marks or were injured?	Yes ☐ No ☐

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3. Did an adult or person at least 5 years older than you **ever**… Touch or fondle you or have you touch their body in a sexual way? **OR** Try to or actually have oral, anal, or vaginal sex with you?	Yes ☐ No ☐
4. Did you **often** feel that … No one in your family loved you or thought you were important or special? **OR** Your family didn't look out for each other, feel close to each other, or support each other?	Yes ☐ No ☐
5. Did you **often** feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **OR** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	Yes ☐ No ☐
6. Were your parents **ever** separated or divorced?	Yes ☐ No ☐
7. Was your mother/father or stepmother/stepfather: **Often** pushed, grabbed, slapped, or had something thrown at her? **Or Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard? **Or Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?	Yes ☐ No ☐
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	Yes ☐ No ☐
9. Was a household member depressed or mentally ill or did a household member attempt suicide?	Yes ☐ No ☐
10. Did a household member go to prison?	Yes ☐ No ☐
Total of "Yes" scores:	_____

PATIENT/CAREGIVER SIGNATURE:

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

Patient Signature Date	If applicable, Guardian Signature Date

HISTORY REVIEW:

Clinician comments:

Clinician Signature Date	Registrar Signature Date