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?