# Family Health Care

# Child Initial History
# (Ages 3 – 12)

Dear Parent/Guardian,

Behavioral and emotional health is important to a person's overall health. That's why we have a Behavioral Health Team at our clinic. To help us best assess this critically important part of your child's health, please fill out these forms. Your answers will help us best support your child and your family.

- **Child Initial History Form** (2 pages): This form asks about your child's main areas of concern and symptoms.

- **The Child/Adolescent Psychiatry Screen – CAPS** (2 pages): This form lists 85 problems or behaviors that kids may experience and you are asked to check the category that best describes what is true of your child for each one.

Please complete both of these forms as completely and accurately as you can. Your counselor will ask for them and go over them with you during your first appointment. We find them very helpful in understanding you/your child's situation more quickly so we can better know how to start helping things improve.

If you have any questions or concerns, please call us at the clinic you are visiting:

- Cadillac (231)-775-6521
- Baldwin (231) 231-745-4624
- Grant (231) 834-0444
- White Cloud (231)-689-5943

*Thank you,*

*The Behavioral Health Team*

# Child Initial History Form

**Today's Date:** _____ **Child's Name:** _____ **Date of Birth:** _____
**Completed by:** _____ **Relationship to child:** ☐ **Parent** ☐☐

## 1. What are the main problems that you're concerned about regarding your child or adolescent?

Physical: 1._____ 2._____ 3._____

Emotional: 1._____ 2._____ 3._____

**When were these problems first noticed?** _____

## 2. Has your child been treated for mental health disorders in the past? ☐ YES ☐ NO

**IF YES,** how many episodes? _____

What treatments were tried? ☐ medication ☐ counseling ☐ hospitalization ☐ other: _____

Was treatment successful? Explain: _____

## 3. Has your child had, or complained about, any of the following conditions in the past 6 months?

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Chest pain | ☐ | ☐ | Shortness of breath | ☐ | ☐ | Tension headache |
| ☐ | ☐ | Fatigue | ☐ | ☐ | Back pain | ☐ | ☐ | Migraine headache |
| ☐ | ☐ | Dizziness | ☐ | ☐ | Stomachache | ☐ | ☐ | Irritable bowel syndrome |

Has your child been diagnosed with a chronic medical condition? ☐ asthma ☐ diabetes ☐ other:_____

## 4. Chronic pain assessment

YES NO

☐ ☐ Has your child had pain on a daily basis for the last 6 months or more? If so, please ask your child to choose the face that best describes the average daily level of pain.


From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: *Wong's Essentials of Pediatric Nursing*, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

Average pain level (0-10) _____

## 5. Sleep assessment

YES NO

☐ ☐ Does your child have problems sleeping? If **YES**, answer the following:

How long has your child had sleep problems? _____

On average, how many nights each week does your child have sleep problems? _____

On average, how many hours does your child sleep when he/she is having problems? _____

Which of the following best describes your child's sleep problem? _____

- ☐ My child has trouble falling asleep. She /he usually falls asleep at:_____pm/am
- ☐ My child often wakes up during the night.
- ☐ My child wakes up early and can't go back to sleep.
- ☐ My child sleeps all the time and wants to take naps that I think are inappropriate.

_____ (0-10) How bad is your child's sleep problem? 0 not present 1 2 a little bad 3 4 5 pretty bad 6 7 8 very bad 9 10 couldn't be worse

## 6. Medications

YES NO

☐ ☐ Is your child currently taking—or has your child taken—any medications (for example, a stimulant or antidepressant) for behavioral or emotional problems? If **YES**, please fill in the information below for each medication. If you need more space, use the back of this page.

| Name of medication | Dose | When Started? | Still Taking? | How well did it work? | What side effects? |
|---|---|---|---|---|---|
| | | | Yes | | |
| | | | Yes | | |
| | | | Yes | | |

# Child Initial History Form

**Today's Date:** _____ **Child's Name:** _____ **Date of Birth:** _____

**7. Family history:** Does your child have any biological relatives who have behavioral, emotional, or mental problems (☐ ADHD, ☐ depression, ☐ anxiety, ☐ bipolar disorder, ☐ drug or alcohol abuse, ☐ suicide, ☐ other: _____)?

**YES** **NO**

☐ ☐ If **YES**, list which relatives and describe problems: _____

_____

_____

**8. History of abuse and traumatic events:** Does your child have a history of any of the following?

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Drug or alcohol abuse | ☐ | ☐ | Emotional abuse | ☐ | ☐ | Prenatal smoking or drug |
| ☐ | ☐ | Physical abuse | ☐ | ☐ | Traumatic (very upsetting) events | ☐ | ☐ | Prematurity or birth trauma |
| ☐ | ☐ | Sexual abuse | | | | | | |

☐ ☐ Are any of the above occurring now, or still affecting your child?

☐ ☐ If **YES**, have you sought help from a professional? If so, who? _____

**9. Environmental stressors, peer relationships, and school history**

**YES** **NO**

☐ ☐ Are there any other things—now or in the past—that you think might be negatively affecting your child's behavior or emotions?
If **YES**, please describe: _____

☐ ☐ Are your child's physical or emotional problems affecting how he/she deals with others?
If **YES**, please describe: _____

☐ ☐ In the last 6 months, has your child missed any school because of mental health problems?
If **YES**, how many days? # days missed _____

☐ ☐ Has your child missed more than 1 week of school for mental health problems?

☐ ☐ Has your child been tested by any member of the resource team at school, or has your child been enrolled in any special education services? (If **YES**, please bring a copy of test results or individual education plans (IEPs) to your appointment.)

**10. Impairment rating scale.** Check the number by the statement that best describes how much you think your child is impaired (negatively affected or hurt) by his problems right now. (Compare your child to typical children of the same age and gender, in the same situations.)

☐ **1 No impairment.** Symptoms are not present any more than expected, and do not impair normal functioning at home or school.

☐ **2 Slight impairment.** Symptoms are present a little more frequently or intensely than expected, and only rarely impair normal functioning at home or school.

☐ **3 Mild impairment.** Symptoms are present somewhat more frequently or intensely than expected, and usually impair normal functioning at home or school.

☐ **4 Moderate impairment.** Symptoms are present a lot more frequently or intensely than expected, and usually impair normal functioning at home or school.

☐ **5 Severe impairment.** Symptoms are present a great deal more frequently or intensely than expected, and most of the time impair normal functioning at home or school.

☐ **6 Very severe impairment.** Symptoms are present so much more frequently or intensely than expected that they almost always impair normal functioning at home or school.

☐ **7 Maximal (profound) impairment.** Symptoms are present so frequently or intensely that they produce significant and pervasive impairment, which creates a crisis requiring immediate action to prevent serious deterioration to avoid or prevent harm.