CHILD INITIAL HISTORY FORM

Today's Date: _____ Child's Name: _____ DOB: _____

Completed By: _____ Relationship to Child: _____

What are the main issues that you're concerned about regarding your child or adolescent?

Physical 1._____ 2._____ 3._____

Emotional 1._____ 2._____ 3._____

When did you first notice these issues? _____

Has your child been treated for mental health disorders in the past? (Circle one) **Y / N**

If yes, how many episodes? _____

What treatments were tried? (Circle all that apply) Medication Counseling Hospitalization

Was treatment successful? Please Explain: _____

Has your child had, or complained about, any of the following conditions in <u>the past six (6) months</u>?

YES	NO		YES	NO		YES	NO	
		Chest Pain			Shortness of Breath			Tension Headache
		Fatigue			Back Pain			Migraine Headache
		Dizziness			Stomach Ache			Irritable Bowel Syndrome

Has your child been diagnosed with a chronic medical condition? (Circle all that apply) Asthma Diabetes

Chronic Pain Assessment

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

Sleep Assessment

Does your child have problems sleeping? (Circle one) Y / N If yes, answer the following questions:

How long has your child had sleep issues? _____

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

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? (Check one)

___ 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.
How bad is your child's sleep problem? (On a scale of 1 to 10: 1 being not present, 10 being severe) _____

Medications

Is your child currently taking, or has your child ever taken, any medication for behavioral or emotional problems (for example a stimulant or antidepressant)? (Circle one) Y / N If yes, please complete information below.

Name of Medication	Dose	Date	Currently	How well did it	Side effects?

Today's Date: _____
Name:_____ DOB:_____

		Started	Taking (Yes/No)	work?	

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, etc.) (circle one) **Y / N**

If yes, list which relative and describe issue: _____

_____

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 drugs
		Physical Abuse			Traumatic events			Prematurity or birth trauma
		Sexual abuse			Are any of these still occurring or still affecting your child? If yes, have you sought professional help? If so, who? _____			

Environmental stressors, peer relationships, and school history:

Are there any other things, now or in the past, that you think might be negatively affecting your child's behavior or emotions? Y/N If yes, please explain: _____

Are your child's physical or emotional problems affecting how he/she deals with others? Y/ N

In the last six months, has your child missed any school because of mental health problems? Y / N

If so, how many days? _____

Has your child missed more than one week of school for mental health problems? Y / N

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? Y / N (If yes, please bring a copy of the latest IEP to your appointment.)

Impairment rating scale: Circle the number by the statement that best describes how much you think your child is impaired 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.