Hiawatha Valley
MENTAL HEALTH CENTER

CHILD/ADOLESCENT HISTORY FORM

Today's Date: _____

Name of Person Completing this form: _____ **Relationship to the client:** _____

IDENTIFYING INFORMATION					
Child's Name:	Last	First	Middle	DOB	Age
Address:	Street		Social Security No.		
	City	State		Zip	
Telephone:	Home	Cell			
Ethnicity:	☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline				
Race:	☐ American Indian ☐Alaska Native ☐ Asian ☐ African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Unknown				
Language:	☐ English ☐ Spanish ☐ Hmong ☐ Mandarin ☐ Other _____				

What are your major concerns:

Did someone suggest you bring your child to see someone? ☐ **Yes** ☐ **No** ***If yes, answer the following***

Name of Referral:	
Address:	
Telephone:	

Do you want a summary sent to this person? ☐ **Yes** ☐ **No**

Services Requested and/or available to you and your child:	☐ Therapy ☐ Psychological Testing ☐ Psychiatry (medication) ☐Children's Therapeutic Services and Supports ☐ School Based/Linked therapy or skills training ☐ Substance Abuse Treatment ☐ Children's Mental Health Case Management

LIVING SITUATION

Primary Household

List all people the child lives with

Name(s)	Age(s)	Relationship(s) to Child

Street Address *(if different from child's address listed above)*

Does the child live in more than one household? ☐ **Yes** ☐ **No**

If *yes, complete secondary household information. If no, skip to additional family members*

Secondary Household

List all people the child lives with

Name(s)	Age(s)	Relationship(s) to Child

Street Address *(if different from child's address listed above)*

Additional Family Members: *Please list the child's parents, brothers and sisters that the child does not live with*		

Custody Arrangement*: Please describe the physical and legal custody arrangement for your child. Please provide related custody documents.*

Guardianship Arrangement: *Please provide guardianship documents for the child*

DEVELOPMENTAL ISSUES

Have you ever had concerns about the following issues with this child?

Pregnancy	Had bleeding in the first three (3) months	☐ Yes ☐ No ☐ Unknown
	Had bleeding during the second three (3) months	☐ Yes ☐ No ☐ Unknown
	Had bleeding during the last three (3) months	☐ Yes ☐ No ☐ Unknown
	Had toxemia	☐ Yes ☐ No ☐ Unknown
	Had to take medications ☐ Yes ☐ No ☐ Unknown Specify medications:_____	
	Got injured or hurt	☐ Yes ☐ No ☐ Unknown
	Took narcotic drugs	☐ Yes ☐ No ☐ Unknown
	Drank alcohol	☐ Yes ☐ No ☐ Unknown
	Smoked during pregnancy	☐ Yes ☐ No ☐ Unknown
	Length of pregnancy	
	Other pregnancy problems/illness, specify:	
Birth/Early Infancy	Born prematurely	☐ Yes ☐ No ☐ Unknown
	Born with cord around neck	☐ Yes ☐ No ☐ Unknown
	Injured during birth	☐ Yes ☐ No ☐ Unknown
	Had trouble breathing	☐ Yes ☐ No ☐ Unknown
	Turned blue	☐ Yes ☐ No ☐ Unknown
	Was a twin or triplet	☐ Yes ☐ No ☐ Unknown
	Had seizures	☐ Yes ☐ No ☐ Unknown
	Needed oxygen	☐ Yes ☐ No ☐ Unknown
	Was very jittery	☐ Yes ☐ No ☐ Unknown

		Yes	No	Unknown	Age First Noted	Still Occurring
Childhood Health Issues	Seizures					
	High fevers					
	Head injury					
	Asthma					
	Trouble with hearing					
	Trouble with vision					
	Lead poisoning					
	Other poisoning or overdose					
	Other serious illness					
	Other hospitalizations					

		Yes	No	Unknown	Age First Noted	Still Occurring
Early Attachment--- Functioning	Poor appetite					
	Constipation					
	Stomach Aches					
	Trouble falling asleep					
	Trouble staying asleep					
	Overactivity					
	Head banging					
	Rocking in bed					
	Temper tantrums					
	Self-destructive					
	Difficulty being comforted					
	Stiffness or rigidity					
	Crying often and easily					
	Shyness with strangers					
	Irritability					
	Extreme reaction to noise					
	Change/loss of primary caregiver					

CHILD'S SCHOOL FUNCTIONING- *Current school information including school name and grade*

Does your child receive special education services? ☐ Yes ☐ No

If no, has your child ever been tested and determined not to need services?

If yes, when was your child tested? If yes, by whom?

Comment on any strengths/concerns for child in educational setting

CHILD'S LEGAL HISTORY

Does your child have a history of legal charges? ☐ Yes ☐ No
If yes, describe charges:

Is your child currently on probation? ☐ Yes ☐ No

Has your child ever been on probation? ☐ Yes ☐ No

Has your child ever been court-ordered into chemical health or mental health treatment? ☐ Yes ☐ No

CHILD'S TRAUMA HISTORY

Has your child ever experienced any of the following?	Physical neglect:	☐ Yes ☐ No
	Sexual abuse/molestation:	☐ Yes ☐ No
	Emotional abuse:	☐ Yes ☐ No
	Community violence:	☐ Yes ☐ No
	Car accident:	☐ Yes ☐ No
	Death of parent:	☐ Yes ☐ No
	Natural Disaster:	☐ Yes ☐ No

Other, please describe:
If yes to any, please describe:

CHILD'S MENTAL HEALTH TREATMENT	
Previous and current mental health treatment?	☐ Yes ☐ No *If yes, please list reason for treatment, provider name and dates of services:*
Currently on any medications?	☐ Yes ☐ No *If yes, please list medication:*
Are you allergic to any medications?	☐ Yes ☐ No *If yes, please list medication:*
CHILD'S ALCOHOL AND DRUG HISTORY	
Do you have any concerns about your child's use of drugs or alcohol?	☐ Yes ☐ No *If yes, please describe*
Smoking Status	☐ Former Smoker ☐ Never ☐ Unknown If Current Smoker: ☐ Somedays ☐ Every Day
Has your child gone to or is your child currently participating in chemical dependency treatment?	☐ Yes ☐ No *If yes, please list reason for treatment, providers name and dates of services:*
If appropriate, ask your child to answer the following questions: Have you used more than one chemical to get high? ☐ Yes ☐ No Do you avoid family activities so you can use? ☐ Yes ☐ No Do you have a group of friends who also use? ☐ Yes ☐ No Do you use to improve your emotions, such as when you feel sad or depressed? ☐ Yes ☐ No	
HEALTHCARE PROVIDER INFORMATION	
Does your child have a regular physician? ☐ Yes ☐ No *If yes, please list name, address and phone number:*_____	
Do you want a summary sent to this person? ☐ Yes ☐ No	
When was your last physical?	

PLEASE CONTINUE TO NEXT PAGE

		Instructions ***(to the parent or guardian of child)***: The questions below ask about things that might have bothered your child. (age 6-17 years old) 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**.	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain core** (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 than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
VI.	8.	Seemed angry or lost his/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 been 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.)?	◎ 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)?	◎ 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		

Signature of Person Completing Form: X _____ **Date:** _____