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CLINICAL SERVICES

Child & Adolescent History Form

Client's Name: _____ Date of Birth: _____ Age: ___

Preferred Name: _____ Preferred Pronouns: _____

Gender Identity: _____ Sexual Orientation: _____

Cultural / Ethnic / Racial Background: _____

Person completing this form if other than client: _____ Relation to Client: _____

Child lives with: Both parents Joint parenting Mother Father Other

Name of Primary Care Provider &/or Clinic Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Provider Phone: _____ Provider Fax: _____

May we contact your primary care provider if therapeutically useful? Yes No

Are there other Professionals that we may need to contact on behalf of your child?

(Name/Title/Phone): _____

Name of Child's School: _____ Grade: _____ District: _____

Teacher: _____ Counselor:_____

Phone: _____ Fax: _____

How were you referred to Sundstrom Clinical Services? _____

Reasons For Seeking Services

Please describe your concerns and goals:

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SYMPTOMS / ISSUES: Please enter 1-3 for degree of difficulty. (1=minor, 2=moderate, 3=severe, blank=absent)

	Sad / Depressed		Little sleep/ not tired		Disorganized		Lying/ sneaking
	Decreased energy		Withdrawn/ aloof		Memory problems		Fire setting
	Hopelessness		Excessive energy		Difficulty with planning		Blackouts
	Worthlessness		Racing thoughts		Difficulty w/ decisions		Hallucinations
	Loss of enjoyment		Anxiousness		Hyperactivity		Delusions
	Irritability		Uncomfortably socially		Impulsivity		Feel not in your body
	Grief and loss		Panic attacks		Risk taking behavior		Toileting problems
	Guilt		Obsessions		Learning problems		Eating problems
	Loss of enjoyment		Compulsions		Language problems		Eating disorder
	Suicidal thoughts		Perfectionism		Rigid/ inflexible		Abuse victim
	Self-harm		Scared/ fearful		Immature		Abuse perpetrator
	Lack of energy		Resistance to school		Repetitive movements		Trauma history
	Sleep issues		Easily embarrassed		Tics		Substance use
	Appetite changes		Fear of bedtime		Uncoordinated		Pornography issues
	Weight changes		Security blanket/object		Sensory issues		Sexual issues
	Aggressive/ angry		Difficulty concentrating		Peer difficulties		Abortion
	Mood swings		Can't follow directions		Violent		Other:
	Excessive good mood		Can't get started on tasks		Rule breaking		

Please describe any other issues or concerns:

Please describe any actions taken to address symptoms:

Do you have any current mental health diagnoses**?** Yes No

If yes, please list your mental health diagnoses:

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Complete if 12 years old or older: Patient Health Questionnaire (PHQ-A): Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling asleep or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, or that you are a failure or have let yourself or family down				
Trouble concentrating on things, such as reading the newspaper or watching TV				
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself.				

In the past year have you felt depressed or sad most days, even if you felt OK sometimes? Yes No

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life?

Yes No

Have you ever, in your whole life, tried to kill yourself or made a suicide attempt? Yes No

Overall, how satisfied are you with your child's behavior over the last few months:

Very Satisfied Somewhat Satisfied Somewhat Dissatisfied Very Dissatisfied

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Family Demographics

People in your child's family and household(s):

Name	Relationship	Age	Grade/Job:	Guardianship	Live out of home
				Yes	Yes
				Yes	Yes
				Yes	Yes
				Yes	Yes
				Yes	Yes
				Yes	Yes
				Yes	Yes
				Yes	Yes

Additional information:

Parent/gaurdian occupations:

If biological parents are different from above please list below:

Parent 1: _____ unknown Parent 2: _____ unknown

If child lives in multiple homes, what are the plan details or custodial arrangements:

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Prior Treatment Or Assessment

Prior Mental Health Treatment: Yes No

Please describe any prior outpatient treatment (when, where, provider's name):

Has your child been hospitalized for psychiatric symptoms: Yes No

If yes, please briefly explain:

Prior Testing or Evaluation: Yes No

Please describe tests administered, results, diagnoses, conclusions, recommendations, etc.:

Family Background

Family stressors:

- Death
- Divorce
- Health issues
- Financial difficulties
- Job Loss
- Moves
- Other:

If divorced, parental relationship is:

- Amicable
- Minimal communication
- Conflictual
- Not in contact
- High conflict (violence, no-contact order, etc.)

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History of mental health conditions in the following family members:

	Bio Father	Bio Mother	Other Guardians	Siblings	Other Bio Relatives	Others In Home
Substance abuse:						
Alcohol abuse:						
Depression:						
Anxiety/ Panic:						
Bipolar:						
Moodiness/ Anger						
ADHD:						
Developmental delays/ MR:						
Autistic Spectrum Disorder						
Learning disabilities:						
Tics/ Tourette's						
Psychosis:						
Seizures:						
Suicide:						
Dementia:						
Outpatient psychotherapy						
Inpatient treatment						

Briefly describe pertinent family concerns:

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Briefly describe parent's relationship, sibling relationships, atmosphere in the home, cultural/ethnic backgrounds, religion, hobbies, activities, etc.:

Do you participate in spiritual activities? Yes No Where:

Do you want spirituality to be part of treatment? Yes No Unsure

Developmental Background

Prenatal

Mother's age at birth:
Father's age at birth:
Prenatal care: No Yes
Complications:
Substance Use: None
Prescriptions
Alcohol
Caffeine
Tobacco
Recreational drugs

Developmental milestones

	Ave Month	Other
Overall development		
Crawled	6-9	
Walked 2-3 steps	9-18	
Followed commands	12-18	
Single words	12-24	
2+ word sentences	24-35	
Toilet trained daytime	13-36	

Handedness?
Right Left
Both

Other issues

Poor muscle control
Muscle Tone
Difficulty toileting
Difficulty sleeping
Picky eater
Failure to thrive
Sensory issues
Difficult to soothe
Under responsive
Disconnected socially

Birth History

Vaginal
C-section
Unknown
On time (38-42wks)
Other:
Delivery complications
Adopted (describe below)

Daily Living

	Independent	Needs help	Causes battles
Dressing/bathing			
Eating			
Getting food, etc.			
Chores/Cleaning			

Weight at delivery: lbs. oz.

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Birth, Adoption, & Developmental History and Concerns:

Has your child experienced a significant trauma? *(Physical; sexual; emotional; verbal; neglect; exposure to violence, drugs, or sexually explicit material; death; illness; injury; other, etc.)*

Behavioral Background

Social Support

- Excellent
- Fair
- Poor

Prefers peers ages:

- Younger
- Older
- Varies

- Has best friend/s
- Poor intimacy with friends
- Friends are poor influence
- Few / No friends
- Little interest in other kids
- Gets invitations from kids
- Gets bullied / bullies others
- Spends night away from home

Behavior & Discipline Effective Ineffective Makes it worse

- Loss of Privileges
- Grounded from Peers
- Grounded: Tech
- Do an extra chore
- Spanking
- Time Out
- Other:

Extra-curricular/Hobbies:

Describe any social and behavioral concerns:

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Describe your child's and the family's habits around technology usage:

Academic Background

Academic performance:	**History of:**	
Excellent:	Upset when leave parents	Skipping School
Good	Not wanting to go to school	Grade retention
Fair	Behavioral outbursts	Late/missing work
Poor	Poor friendships	IEP / 504
Best subjects:	Frequent conflict	Behavioral supports
Worst subjects:	Bullying	
Age started school	Physical complaints	

GPA (if applicable):

Did your child receive early intervention services: Yes No

Briefly describe any academic concerns:

Medical Background

Current physical health:	**Medical history of:**	
Excellent	Allergies (list below)	Neurologic condition (e.g. seizures, head injury)
Fair	Accidents	Endocrine condition (e.g diabetes, thyroid, PCOS)
Poor	Surgeries/hospitalizations	GI condition (e.g., chron's, UC, IBD, GERD)
	Stomach aches	Genetic condition (e.g., sickle cell, PKU)
Exercise Regularly?	Headaches	Other:
Yes No	Constipation	
	Pain	

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Please list known allergies and briefly describe any pain or chronic health conditions, or describe any significant medical history and concerns:

Please list any current physical health diagnoses and any treatment you may have had or are receiving for your health condition:

Sleep: Average hours of sleep: Time to bed: Time wake:

Overall sleep quality?	Snoring	Difficulty falling asleep	Restless sleeper
Excellent	Sleep walking	Difficulty staying asleep	Other:
Fair	Nightmares/terrors	Early morning waking	
Poor	Afraid to sleep alone	Bedtime behavior problems	

Eating: Eats too little Eats too much Picky Strong aversion to textures

Has your child had a recent significant**:** Weight loss lbs. Weight gain lbs.

Has your child seen any medical provider (MD, NP, DO, or specialist) within the past year: Yes No

Please list all mental health medications your child is **currently taking**, name and dose, and a brief explanation of how they are working: None

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Please list all mental health medications your child has **previously tried**, name and dose, and a brief explanation of how they responded: None

Please list all other medications (prescribed or over the counter) your child is **currently taking**, name and dose, and a brief explanation of what they are for: None

Please provide any information on why medications were discontinued or any adverse side effects:

Does your child follow their medication regime? Yes No

If no, please explain:

Please describe any other significant medical history and concerns:

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Areas of Risk

To your knowledge, has your child ever reported any of the following?			Does not apply
Feelings of hopelessness	Never	Past	Present
Wish to not be here/ end distress	Never	Past	Present
Thoughts of harming self	Never	Past	Present
Self-harm actions (e.g., cutting, mutilation)	Never	Past	Present
Suicidal Attempts	Never	Past	Present
Wish to harm others	Never	Past	Present

Never	Past	Present	
			Severe feelings of hopelessness
			Wish to not be alive or end distress
			Thoughts of harming self
			Actions to harm self (e.g., cutting, mutilation)
			Suicidal attempts
			Wish to seriously harm others

To your knowledge, does your child consume these substances**:** (*Please include frequency/amount*)**:**

	Current	**Suspected**	**Past**	**No**
Caffeine				
Tobacco				
Alcohol				
Prescription meds				
Illegal/ recreational substances				
Other:				

Prior treatment: Describe: