CORE Professional Services, P.A.

Personal Health & History (Child/Adolescent Form)

Private and Confidential

First Name:	Last Name:	Middle Name:
Date of Birth:	Current Age:	Today's Date
Place of Birth:		
To which gender identity do you most identify?	☐ Female ☐ Transgender Female ☐ Gender Variant ☐ Not listed: _____	☐ Male ☐ Transgender Male ☐ Prefer not to answer

Family History

Parent #1:	Parent 1's Occupation (job):
Parent #2:	Parent 2's Occupation (job):
List Full Siblings' Names & Ages	
Does Parent 1 have other children? Yes/No	If Yes, list names & ages:
Does Parent 2 have other children? Yes/No	If Yes, list names & ages:
If applicable, list step-sibling names & ages:	
Does anyone else in your family have criminal charges? Yes/No List who & what they were charged with:	

Are there any other significant people who live in the child's household (example: step-parents, birth-parents, step or half-siblings, grandparents, foster family, family friends, or others)?
☐ No ☐ Yes

Name	Relationship to Child	Age	Male or Female	Where They Live

BACKGROUND INFORMATION

Child has lived with (check all that apply):

☐ Both parents
☐ A single parent
☐ A blended family (step-parent, step-brothers/sisters, half-brothers/sisters, etc.)
☐ An adoptive family
☐ Relatives, but not parents (specify): _____
☐ Out of home placements (foster homes, group homes, institutions, etc.)
☐ Other (specify): _____

LIFE EXPERIENCES

The following experiences have happened to the child or someone close to the child	This happened to the child	This happened to someone whom the child was close
Alcohol or drug abuse	☐ Yes ☐ No	☐ Yes ☐ No
Physical abuse or battering	☐ Yes ☐ No	☐ Yes ☐ No
Sexual abuse, molestation, or rape	☐ Yes ☐ No	☐ Yes ☐ No
Neglect	☐ Yes ☐ No	☐ Yes ☐ No
Physical disability	☐ Yes ☐ No	☐ Yes ☐ No
Chronic illness	☐ Yes ☐ No	☐ Yes ☐ No
Mental illness	☐ Yes ☐ No	☐ Yes ☐ No
Mental retardation	☐ Yes ☐ No	☐ Yes ☐ No
Learning disability	☐ Yes ☐ No	☐ Yes ☐ No
Attention Deficit / Hyperactivity	☐ Yes ☐ No	☐ Yes ☐ No
Suicide or suicide attempts	☐ Yes ☐ No	☐ Yes ☐ No
War experiences	☐ Yes ☐ No	☐ Yes ☐ No
Loss of a loved one through death	☐ Yes ☐ No	☐ Yes ☐ No
Frequent moving or relocation	☐ Yes ☐ No	☐ Yes ☐ No
Natural disaster (flood, earthquake, tornado)	☐ Yes ☐ No	☐ Yes ☐ No
Abduction or kidnaping	☐ Yes ☐ No	☐ Yes ☐ No

The following experiences have happened to the child or someone close to the child	This happened to the child	This happened to someone whom the child was close
Removal from home / parents	☐ Yes ☐ No	☐ Yes ☐ No
Legal / court / incarceration / probation involvement	☐ Yes ☐ No	☐ Yes ☐ No
Economic status of child	Low Working	Middle Upper

ALCOHOL / DRUG USE

Does the child use alcohol or drugs? ☐ Don't know
☐ No
☐ Yes, (specify): _____

For children ages 10 and over:

Have you ever felt you had to cut down on your drinking or drug use? ☐ Yes ☐ No

Have you ever had people annoy you by criticizing your drinking or drug use? ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

Have you ever had a drink or used drugs as an eye opener first thing in the morning to steady your nerves, get rid of a hangover, or to get the day started? ☐ Yes ☐ No

CHILD'S EDUCATIONAL STATUS

School Child Attend _____ Current Grade _____

Special needs or concerns associated with the child's educational environment
(check all that apply):

☐ Reading ☐ Writing
☐ Math ☐ Hearing and understanding verbal information
☐ Getting along with school mates ☐Getting along with teachers
☐ Speech ☐ Attendance/skipping classes/refusal to go to school
☐ Attention deficit/hyperactivity ☐ Other (specify) _____

Child is currently receiving special education services: ☐ No ☐ Yes
Type of Service: _____
When did the service start: _____

OTHER INFORMATION

Activities which are an important part of the child's life include:

☐ Church (specify): _____
☐ Membership in clubs or organization (specify): _____
☐ Interests (specify): _____
☐ Hobbies (specify): _____
☐ Athletics (specify): _____
☐ Volunteer activities (specify): _____
☐ Employment (specify): _____
☐ Chores (specify): _____
☐ Other (specify): _____

MEDICAL INFORMATION

Child's physician's name is: _____

The medical clinic which child goes to is: _____

Child receives treatment from other physicians or specialists: ☐ No
☐ Yes (please specify):

Specialist's Name:	Address:	Reason:
_____	_____	_____
_____	_____	_____

The date of the child's last physical exam was:_____
The results of the child's last physical exam were:_____

Child is currently having medical problems or symptoms: ☐ No
☐ Yes (please specify):

_____

Child has allergies: ☐ No
☐ Yes (please specify):
☐ To medications ☐ To pollen/dust
☐ To other things:_____

CURRENT MEDICATIONS CHILD TAKES

Name of medication	The reason child takes this medication	The dose child takes each time	The frequency with which child takes this medication	The last dose child took was (when)	The date child first began taking this medication was	Child is taking this medication as prescribed
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

PRIOR MEDICAL CONDITIONS (check all that apply):

☐ Child had a head injury	Describe:
☐ Child had seizures or convulsions	Describe:
☐ Child had unusual behaviors or body movements	Describe:
☐ Child had serious illness	Describe:
☐ Child had surgery(s)	Describe:

☐ Child had other serious injuries	Describe:
☐ Child had hospitalization(s)	Describe:
☐ Child had lead poisoning or other poisoning	Describe:
☐ There have been medical problems in child's parents, brothers, or sisters	Describe:

ADDITIONAL SERVICES CHILD RECEIVES

Child is receiving help from Social Services for:	The name of the worker is:	The reason is:
1. Financial Assistance, ☐ Yes ☐ No 2. Child Welfare Issues, ☐ Yes ☐ No 3. Case Management, ☐ Yes ☐ No 4. Other social services, ☐ Yes ☐ No	1._____ 2._____ 3._____ 4._____	1._____ 2._____ 3._____ 4._____
Child receives In-Home Family Services ☐ Yes ☐ No	_____	_____
Child receives Home Health/County Nursing Services ☐ Yes ☐ No	_____	_____
Child receives Probation Services ☐ Yes ☐ No	_____	_____
Child receives other court/legal services ☐ Yes ☐ No	_____	_____

MENTAL HEALTH HISTORY

Name of counselor / therapist / doctor	Name of clinic / hospital	Address / city / state	The date(s) child went there were

The following mental health problems were/are present in child's family (parents, brothers, sisters, and other relatives):	
☐ Depression ☐ Bipolar Disorder (Manic Depression) ☐ Schizophrenia ☐ Panic attacks ☐ Suicide ☐ Alcohol abuse/dependence ☐ ADHD/ADD (Hyperactivity) Other	Previous diagnoses of child: _____ _____ _____ _____ _____

CURRENT MENTAL HEALTH CONCERNS

The concern which led to child's appointment here is:_____
_____
_____

How does the child feel about the issues bringing them to counseling:
_____
_____
_____

SELF-HARM CONCERNS

Child has <u>recently experienced</u> a desire or urge to kill her/himself.
☐ No ☐ Yes ☐ Don't know
Child has <u>attempted</u> to kill her/himself in the past.
☐ No ☐ Yes ☐ Don't know
Child is <u>currently experiencing</u> thoughts or urges to injure or harm her/himself.
☐ No ☐ Yes ☐ Don't know
Child has <u>engaged in</u> self-injurious or harmful behaviors.
☐ No ☐ Yes ☐ Don't know

VIOLENCE CONCERNS

Child has <u>recently experienced</u> a desire or urge to seriously harm or kill <u>someone else</u>.
☐ No ☐ Yes ☐ Don't know
Child has attempted to harm/hurt other people in the past (hitting, shoving, choking, punching, kicking, etc.).
☐ No ☐ Yes ☐ Don't know
Child has a history of violent or destructive behavior.
☐ No ☐ Yes ☐ Don't know

TREATMENT GOALS

What is <u>hoped to change</u> by having the child come here is:_____
_____
_____

Current Problem Checklist

As you are filling this out please remember you do not need to experience these symptoms every day. The symptoms may present themselves when you are having a problematic day or period of time. NOTE: If your answer is sometimes, circle YES and explain how often this symptom occurs.

<u>NEUROVEGETATIVE</u>

Changes in sleeping pattern: **YES / NO** _____
Energy Level: **YES / NO** _____
Interest in pleasures: **YES / NO** _____
Appetite-Weight loss/gain: **YES / NO** _____

MOOD

Depressed, Despondent, Sad:	**YES / NO**	_____
Social withdrawal/Isolating:	**YES / NO**	_____
Deterioration of personal hygiene:	**YES / NO**	_____
Feeling hopeless/helpless/worthless:	**YES / NO**	_____
Feeling guilty:	**YES / NO**	_____
Trouble concentrating:	**YES / NO**	_____
Lacking motivation:	**YES / NO**	_____
Constant worrying:	**YES / NO**	_____
Memory difficulty:	**YES / NO**	_____
Euphoria:	**YES / NO**	_____
Irritability/Feeling angry:	**YES / NO**	_____
Decreased need for sleep:	**YES / NO**	_____
Flight of Ideas:	**YES / NO**	_____
Grandiosity:	**YES / NO**	_____
Hyperverbal:	**YES / NO**	_____
Racing Thoughts:	**YES / NO**	_____
High-Risk Behavior:	**YES / NO**	_____
Mood Swings:	**YES / NO**	_____
Increased psychomotor activities:	**YES / NO**	_____

ADHD

Motor Activity:	**YES / NO**	_____
Short Attention Span:	**YES / NO**	_____
Distractibility:	**YES / NO**	_____
Impulsivity:	**YES / NO**	_____

ANXIETY

Uncontrollable Worry:	**YES / NO**	_____
Nervous/On Edge:	**YES / NO**	_____
Easily Fatigued:	**YES / NO**	_____
Muscle Tension/Restlessness:	**YES / NO**	_____
Panic Attacks (describe):	**YES / NO**	_____
Obsessive-Compulsive Thoughts:	**YES / NO**	_____
Obsessive-Compulsive Behaviors:	**YES / NO**	_____
PTSD Symptoms:	**YES / NO**	_____
Phobias:	**YES / NO**	_____
Somatic Symptoms:	**YES / NO**	_____

THOUGHT DISORDER

Visual/Auditory Hallucinations:	**YES / NO**	_____
Tactile/Olfactory Hallucinations:	**YES / NO**	_____
Command Hallucinations:	**YES / NO**	_____
Delusions:	**YES / NO**	_____
Paranoid Ideations:	**YES / NO**	_____
Other:	**YES / NO**	_____

EATING DISORDER/BODY IMAGE

Increased/Decreased Appetite:	**YES / NO**	_____
Binging:	**YES / NO**	_____
Purging:	**YES / NO**	_____
Weight Loss/Gain in the last month:	**YES / NO**	_____
Distorted Body Image:	**YES / NO**	_____

IMPAIRED SOCIAL INTERACTION

Legal Issues, Past or Present:	**YES / NO**	_____
Poor Impulse Control:	**YES / NO**	_____
Anger Control Problems:	**YES / NO**	_____
Violence toward Others:	**YES / NO**	_____
Destruction of Property:	**YES / NO**	_____
Less Interested in Friends and Family	**YES / NO**	_____
Problems at Work/School:	**YES / NO**	_____
Problems in Relationships:	**YES / NO**	_____
Find Rules Hard to Follow:	**YES / NO**	_____
Difficulty in Social Situations:	**YES / NO**	_____
Other:	**YES / NO**	_____

Answers on this form may be changed post diagnostic assessment based on information the client provides in the interview.

Updated 9.29.22