CHILD HEALTH HISTORY FORM

Name: _____ DOB: _____ Date:_____

Person answering questions: _____ Relationship to child:_____

Why are you seeking help?_____

_____

What kind of behavioral health services are you seeking?

____ Therapy/Counseling Only

_____Psychiatric Evaluation and Possible Psychotropic Medication Management (Med Mgmt)

_____ Combination Therapy and Med Mgmt Other: _____

Do you have a current therapist? Please provide their name and location: _____

Do you have a current psychiatrist? Please provide their name and location:_____

Do you have a current primary care doctor? Please provide their name and location:_____

Other specialists/doctors treating you (i.e., speech therapist, neurologist):

_____

Mother's Name:_____ Age:_____ Father's Name: _____ Age:_____

Occupation/Employer:_____ Occupation/Employer_____

Language spoken at home: ____ English ____ Spanish ____ Other: _____

Other Primary Caregivers:_____

If parents are divorced/separated, custody arrangements:_____

_____

Household family members and any siblings living outside of the home:

Name	Age	Sex	Relationship to child

Number of family moves since child was born: ___ Any foster care placements?_____

Other residential or shelter stays? _____

EDUCATIONAL:

Current Grade:_____ School:_____ School District:_____

Has your child ever repeated a grade? If so which one?_____

Current Grades:_____

Is your child in: _____Mainstream classes ___Special Education _____Gifted/Talented ___Alternative School

DEVELOPMENTAL/SOCIAL/MEDICAL HISTORY

Instructions: Please read each question, mark an 'X" *in the appropriate box and add comments where needed.*

Mother's Pregnancy with Child: Delivery: __Vaginal __C-Section Labor induced: __ Y __ N

Forceps used: __Y __N Were there complications? __Y __N

If Yes, please explain:_____

_____

Full Term Pregnancy: __Y __ N If "No", at how many weeks was your child born? _____weeks

How long did your child remain in the hospital after giving birth? _____

Any other comments? (i.e., jaundice, twin birth, breathing problems at birth). Please explain:

_____

_____

How much did your child weigh? lbs oz

Was tobacco, alcohol, prescription medications (in addition to Prenatal Vitamins) or street drugs used during pregnancy? __Y__N If "yes", please explain:_____

_____

MILESTONES : please circle	**Early**	**Normal**	**Late**
Sat without support	6 months	8 months	9 months or older
Crawled by scooting	8 months	9 months	10 months or older
Stood Alone	10 months	11 months	12 months or older
Said 2 words other than "mama/ dada"	10 months	11 months	12 months or older
Walked alone	11 months	12 months	13 months or older
Walked alone well	11 months	15 months	16 months or older
Said 3-6 words	14 months	15 months	16 months or older
Put 2 words together	before 2 years	2 years	older than 2 years
Potty trained (Out of diapers)	2 ½ - 3 years	3 - 3 ½ years	older than 3 ½ years

Social: Does your child talk easily with others? __Y __N

Does your child have friends? __Y __N Does your child play well with other children? _Y __N

Is your child sexually active? _Y_N (comments):_____

_____

Current Mental Health Diagnoses: _____
Past Mental Health Diagnoses:_____

Eating Habits: Does your child have issues with their eating or appetite? __Y __N

Please explain:_____

_____

Sleeping: How many hours does your child sleep? ____ How long does it take you to fall asleep? _____

Does your child have nightmares? ___Y ___N

Sleep walking? ___Y ___ N Night terrors? ____Y ____ N Other:_____

Pain: Is your child in any pain now? ____ Y ___ N Paine Score: 0-10 (10 being worst): _____

(explain if yes):_____

When was your child's last physical exam? _____ last dental exam? _____

Neurological Evaluation ___ Y ___ N : _____

Do they have a history of head trauma? ___ N ___ Y *If yes, please explain:* _____

At what age? _____ Was there a loss of consciousness? ___ Y ___ N

Medical hospitalizations? ___ Y ___ N *If yes, list year and the reasons:* _____

_____

Surgeries/operations? ___ Y ___ N *If yes, list year and the reasons:* _____

_____

Psychological Problems/Mental Illness (Details will be asked during the appointment)

_____

_____

Has your child abused alcohol and/or drugs? __Y __N Please explain:_____

_____

Please list any other medical concerns here: _____

_____

Any Allergies? ____Y ___ N please list specific medication(s), foods and environmental allergies:

_____

PAST PSYCHIATRIC HOSPITALIZATIONS, RESIDENTIAL TREATMENT CENTER PLACEMENTS:

CURRENT PRESCRIBED MEDICATIONS:

_____

CURRENT NON-PRESCRIPTION MEDICATION/HERBAL SUPPLEMENTS/VITAMINS:_____

_____

Legal: _____History of Legal charges (circle: current pending past) For what? _____
_____ History of Probation/Jail/Prison? Where and when:_____

_____

Abuse: Any history of physical or sexual abuse? Do you suspect any physical or sexual abuse? If yes, please explain briefly:_____

Has CPS ever been or is currently involved? If yes, please explain briefly:

_____

Has your child ever witnessed domestic violence? If yes, please explain briefly:_____

_____

SAFETY ASSESSMENT:

Are there guns in your home? __ Yes __ No. If yes, is there safe firearm storage? (i.e., locking guns, locking and separating ammunition, keeping guns unloaded) __ Yes __ No

For safety, which of the following would you be willing to do (check all that apply)? __ Remove guns from home __ Leave guns in home, safely stored __ Lock down sharps (i.e., knives, razors, axes, saws, other tools, etc.) __ Lock down all flammables (i.e., gasoline, lighter fluid, etc.) and lighters __ Lock down chains and ropes __ Lock down all over-the-counter and prescription medications

D3 NICHQ Vanderbilt Assessment Scale—PARENT Informant

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

Parent's Name: _____ Parent's Phone Number: _____

Directions: **Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.**

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. I physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

D3 NICHQ Vanderbilt Assessment Scale—PARENT Informant, continued

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

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

Name:_____Date of Birth:_____
Date:_____

Brief Multidimensional Students' Life Satisfaction Scale (Huebner, 1997)

These six questions ask about your satisfaction with different areas of your life**.**
Circle the best answer for each.

	Terrible	**Unhappy**	**Mostly Dissatisfied**	**Mixed (about equally and dissatisfied)**	**Mostly Satisfied**	**Pleased**	**Delighted**
1. I would describe my satisfaction with my family life as:	**1**	**2**	**3**	**4**	**5**	**6**	**7**
2. I would describe my satisfaction with my friendships as:	**1**	**2**	**3**	**4**	**5**	**6**	**7**
3. I would describe my satisfaction with my school experience as:	**1**	**2**	**3**	**4**	**5**	**6**	**7**
4. I would describe my satisfaction with myself as:	**1**	**2**	**3**	**4**	**5**	**6**	**7**
5. I would describe my satisfaction with where I live as:	**1**	**2**	**3**	**4**	**5**	**6**	**7**
6. I would describe my satisfaction with my overall life as:	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Total	____	_____	_____	_____	_____	_____	_____

Total _____

÷ 6 = _____
Score

LSCC - Behavioral Health Intake/Initial Evaluation Screening Questions Last updated: 03/29/19

Patient Name:_____Patient DOB:_____ Date:_____

In order to help us better understand you/your child and meet your needs, please answer the questions below. Some of these questions might not apply to you/your child. In that case, please answer "No." ***Thank you***

What is your pain level on a scale of 0 (none) – 10 (worst)?_____Location/Nature of Pain:_____

- ○ Yes ○ No Have you had a full medical exam in the last year?
  When?_____By whom?_____Where _____
- ○ Yes ○ No Do you have a Psychiatric Advanced Directive (PAD)? *A Psychiatric Advanced Directive is a legal document that allows another person to act on your behalf if you become acutely ill and unable to make decisions about treatment.*
- ○ Yes ○ No Do you have any of the concerns listed below? Check all that applies:
  - ○ Unintended weight change of 10 or more pounds in the last 3-6 months?
  - ○ An illness or problem that made you change the kind and/or amount of food you eat?
  - ○ Tooth or mouth problems that make it hard for you to eat?
  - ○ A big change in desire to eat, or food intake, over the last 2 weeks?
  - ○ Do you worry that you have lost control over how much you eat? Do you make yourself vomit when you feel uncomfortably full?Do you eat in secret?
- ○ Yes ○ No Are you able to take care of yourself like you used to, or do things like you used to?
- ○ Yes ○ No Are you having trouble with your finances? Are you unable to pay for the things you need?
- ○ Yes ○ No Do you have constant, repeated difficulties with gambling that cause you to suffer emotionally? Personally? Professionally?
- ○ Yes ○ No Are you having trouble reaching your goals in school? Or because of your educational level?
- ○ Yes ○ No Are you having trouble reaching your goals at work? Or because of your work status?
- ○ Yes ○ No Are you having trouble reaching your goals because of legal problems?
- ○ Yes ○ No Are there things about your cultural identity that impact your reasons for seeking help?
  Are there things about your cultural identity that are causing difficulties for you?
- ○ Yes ○ No Are you sexually active?
- ○ Yes ○ No Are you being forced to have sex?
- ○ Yes ○ No Is anyone sexually threatening you, or hurting you? Touching you in a way that makes you uncomfortable?
- ○ Yes ○ No Is anyone physically threatening, or hurting you? Bullying you?
- ○ Yes ○ No Is anyone verbally or emotionally threatening, or hurting you? Making you feel bad about yourself?
- ○ Yes ○ No Is anyone keeping you from:
  - Talking to who you want to?
  - Going where you want to go?
  - Seeing who you want to see?
  - Having food, water, clothing or a place to stay?
  - Going to the doctor or having medicine?
  - Using your money?

Other comments:_____

Name:_____Date of Birth:_____ Date:_____

For Office Use only:

Referral to Primary Care	o	**Not indicated, per screen**	o	**Submitted via NextGen**	o	**Complete/ROI for outside PCP sent**	o	**Deferred due to:**	o **Patient Declined**
Referral to Nutrition	o	**Not indicated, per screen**	o	**Submitted via NextGen**	o	**Resources Letter Generated**	o	**Deferred due to:**	o **Patient Declined**
Other referral(s):			o	**Submitted via NextGen**	o	**Resources Letter Generated**	o	**Deferred due to:**	o **Patient Declined**
			o	**Submitted via NextGen**	o	**Resources Letter Generated**	o	**Deferred due to:**	o **Patient Declined**
			o	**Submitted via NextGen**	o	**Resources Letter Generated**	o	**Deferred due to:**	o **Patient Declined**

Provider Name and Credentials (Print) **Provider Signature** **Date**

Last revised 3.16.2016

Self-Assessment Questionnaire

Name:_____ Date of Birth:_____ Date:_____

For each statement, please mark the answer that best fits your situation. If you are unsure about how to answer any of these statements, please speak to your provider for clarification. Some of these questions may not apply to you or your child, in that case please answer "No." If you are a parent answering for your child, please answer questions from your child's point of view.

Historical Factors		
No	Yes	
		Have you ever had a family member or close friend try to kill themselves?
		Have you ever tried to kill yourself or hurt yourself on purpose?
		Have you ever had thoughts of killing or hurting yourself on purpose?
		Have you ever acted without thinking or without self-control in a way that put yourself or others in danger?

Current Factors		
No	Yes	
		In the past 6 months have you tried to kill yourself or hurt yourself on purpose?
		In the past 6 months have you acted without thinking or without self-control in a way that put yourself or others in danger?
		In the past 6 months have you been violent or aggressive towards people or property?
		In the past 6 months have you had thoughts of killing yourself or hurting yourself on purpose?
		Do you have any plans to kill or hurt yourself or others?
		Are you having a problem making goals or plans for the future?
		Do you intend to harm or kill yourself?
		Do you have difficulty following your doctor or therapist treatment instructions?
		Have you written a suicide note or have you begun giving your important belongings away to others?

Provider Name & Credentials (print):_____
Provider Name & Credentials (signature):_____ Date:_____

Last revised 3.16.2016

Self-Assessment Questionnaire

Name:_____ Date of Birth:_____ Date:_____

No	Yes	
		Have you heard things that other people don't hear? Do they tell what to do?
		Are you losing hope or feel that you are helpless?
		Do you feel like your life has no value or purpose?
		Are you having trouble with sleeping?
		Are you keeping yourself from being with people or doing things with others?
		Do you feel guilty, bad about yourself, or ashamed of yourself?
		Are you feeling more angry or alone?
		Do you feel like your emotions are always "up and down" or out of control?
		Do you feel like you are not safe or that something bad will happen to you?
		Do you have chronic, repeated, or constant pain?

Situational Factors		
No	Yes	
		Do you feel sick when you don't use alcohol or drugs for a short period of time?
		Do you have a long-lasting, serious illness?
		Have you had a recent loss? (example: death of a loved one, loss of a job, divorce or separation)
		Have you had any other recent bad news?
		Do you often argue with friends or co-workers?

Protective Factors		
No	Yes	
		Do you have support from family?
		Do you have support from your spouse/significant other?
		Are you in charge of caring for children or other family?
		Do your friends provide you support when needed?
		Do you have strong religious or spiritual beliefs that keep you safe from hurting yourself?

No	Yes	
		Did you graduate high school or earned your GED?
		Do you have a good way to handle difficult situations?

Provider Name & Credentials (print):_____

Provider Name & Credentials (signature):_____ Date:_____