



Child / Adolescent
Mental Health
New Patient History

Child's Name _____ Child's Last Name _____ Date _____

Address: _____ City: _____ Zip: _____

Child's DOB _____ Child's Age _____ Sex _____ Child's Soc Sec # _____

Phone: _____ Alt. Phone: _____ Ethnicity: _____ Race: _____

Insurance Company: _____ Policy Number: _____ Group Number: _____

Relationship to Insured: _____ Policy Holder Name: _____

Child (under 18 y/o) Adult w/guardian Adult-own Legal Representative

Emergency Contact (Name & Number): _____

Name of Legal Guardian: _____ Relationship: Parent Other Legal

Guardian Address: _____ City: _____ Zip: _____

What brings you here: Case Management Counseling Clinic (Mental Health Meds)

Describe the reason for the clinic visit: _____

Referral Sources: FQHC IDD Providers Hospital Providers Psych Hospitals

Specify: _____

NOTE: Please have the following items with you (if you have them)

- Driver's License
- Social Security Card
- Proof of Household Income
- Insurance Information

Current Symptoms:

- poor appetite overeating insomnia hypersomnia poor impulse control weight loss
- weight gain anxiety isolating loss of interest in activities tearful
- affect doesn't match mood low frustration tolerance enuresis encopresis
- anger verbal aggression physical aggression (inanimate objects animals people)
- poor academic performance hyperactivity poor attention alcohol/drug abuse
- running away suicidal thoughts suicide attempt hallucinations
- delusions (believing things to be true that others do not)
- purposeful self-injury (cutting, burning, scratching, etc...self) other: _____

Describe how long symptoms have persisted: _____

For suicidal thoughts/attempts, explain and give dates: _____

Previous psychiatric care: _____

Hospitalizations (give dates & name of facilities) * request records for hospitalizations within last 3 years

Outpatient psychiatry: (give dates & name of provider) * request records for hospitalizations within last 3 years

Previous medications/dosage/frequency/prescriber/condition being treated/effectiveness:

Current medications/dosage/frequency/prescriber/condition being treated/effectiveness:

Drug Allergies:

Substance Allergies: _____

Medical History

- medical hospitalization
- had surgery
- serious accidents
- had head injury w/unconsciousness
- neurological problems
- cardiovascular problems
- respiratory problems
- diabetes
- thyroid disorder
- liver disease
- gastrointestinal disorder
- musculoskeletal disorder
- chronic pain
- skin problems
- genitourinary/kidney problems
- sexually transmitted disease
- sexual dysfunction
- reproductive problems
- cancer
- vision problems
- hearing problems
- speech problems
- Seizures
- physical activity limited by physical/health problems

Describe all boxes checked: _____

Substance abuse: _____ **Date of last use of alcohol / drugs:** _____

- tobacco use (smoker dip eCigarette)
- alcohol
- marijuana
- synthetic marijuana
- cocaine
- methamphetamine
- narcotic analgesics
- sleeping pills/meds
- benzodiazepines (Xana,Ambien, Valium, Ativan,Klonopin, etc)
- huffing/inhalants other: _____

Describe any current stressors and/or precipitating events:

- Birth
- Death
- employment
- Divorce/relationship dissolution
- homelessness
- financial
- family conflict
- school problems
- health problems
- other: _____

Any Legal Issues: yes / no



dedicated to people | committed to care

Date _____

Social History

Name _____

Family & Marital Status

Do you have children?

Yes

No

If yes, give names and ages, where children live, and describe relationships with children.

Current marital status:

Married

Divorced

Separated

Never Married

Widowed

Unknown

If married (or in a significant relation) more than once, explain reasons for each divorce or separation.

Number of times married: _____

If married or in a relationship, describe relationship with current partner:

Living & Social Situation

Are you satisfied with your current living situation?

Yes

No

Current living arrangement:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Adult Homeless | <input type="checkbox"/> Alone | <input type="checkbox"/> Assisted Living | <input type="checkbox"/> Children Residential Treatment |
| <input type="checkbox"/> Correctional | <input type="checkbox"/> Crisis Residential | <input type="checkbox"/> Family/Relative | <input type="checkbox"/> Foster Care |
| <input type="checkbox"/> Group Quarters | <input type="checkbox"/> Independent | <input type="checkbox"/> Institutional Setting | <input type="checkbox"/> Jail/Correctional Facility |
| <input type="checkbox"/> Medical | <input type="checkbox"/> Other Institutional | <input type="checkbox"/> Residential Care | <input type="checkbox"/> Roommate |
| <input type="checkbox"/> Treatment Training Services | | | |

Number of persons other than you living in the home:

You currently live with (check all that apply):

- | | | | |
|-----------------------------------|--|----------------------------------|---------------------------------|
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Significant Other | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| <input type="checkbox"/> Guardian | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Uncle | <input type="checkbox"/> Aunt |
| <input type="checkbox"/> Son | <input type="checkbox"/> Daughter | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister |
| <input type="checkbox"/> Cousin | <input type="checkbox"/> Foster Parent | <input type="checkbox"/> Friend | <input type="checkbox"/> Other |

Current home atmosphere:

- | | | |
|----------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Loving | <input type="checkbox"/> Comfortable | <input type="checkbox"/> Supportive |
| <input type="checkbox"/> Chaotic | <input type="checkbox"/> Abusive | <input type="checkbox"/> Other |

Describe current living situation:

Overall quality of interpersonal relationships (length, amount of difficulty forming and maintaining):

Describe family involvement:

Financial Situation

Source of income or support received during the past 12 months: _____

Do you have financial problems? Yes No

Have you applied for benefits? Yes No

Explain benefits:

Veteran Background

Type of discharge: Honorable Dishonorable General Other

Do you have a service-related disability? Yes No

Comments on the experience, any trauma, etc.:

Describe the above, or any traumatic experience:

Cultural & Religious Background

Do you identify with a particular cultural group? Yes No

If so, describe group:

Describe religious or spiritual beliefs and practices:

Are cultural and/or spiritual beliefs likely to impact treatment? Yes No

If so, explain why:

Educational Background

Are you currently in school/college/training program? Yes No

Name of school/college/training program: _____

Location of school (city): _____

Last grade completed:

- | | | | | |
|---------------------------------------|--------------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> N/A | <input type="checkbox"/> Head Start | <input type="checkbox"/> Pre-Kinder | <input type="checkbox"/> Kindergarten | |
| <input type="checkbox"/> 1st Grade | <input type="checkbox"/> 2nd Grade | <input type="checkbox"/> 3rd Grade | <input type="checkbox"/> 4th Grade | <input type="checkbox"/> 5th Grade |
| <input type="checkbox"/> 6th Grade | <input type="checkbox"/> 7th Grade | <input type="checkbox"/> 8th Grade | | |
| <input type="checkbox"/> 9th Grade | <input type="checkbox"/> 10th Grade | <input type="checkbox"/> 11th Grade | <input type="checkbox"/> 12th Grade | <input type="checkbox"/> HS Grad/GED |
| <input type="checkbox"/> Some College | <input type="checkbox"/> B.A./Higher | <input type="checkbox"/> Unknown | | |

Do you have a learning disorder? Yes No

Have you been in special education classes? Yes No Unknown

Describe school functioning:

Can you read and write? Yes No Unknown

Explain:

Do you have a history of developmental delay?

Yes

No

If yes, specify:

Employment Background

Current Employment Status:

Full Time

Part Time

NE/FT Student

NE/PT Student

None

Unemployed

Unknown

Are you satisfied with your current job?

Yes

No

How long have you been at your current job?

0-6 months

6 months - 1 year

1-5 years

6-10 years

Over 10 years

Have you experienced difficulty performing work or work-like activity?

Yes

No

Describe the severity/frequency of work problems of any kind:

Relevant work history (begin-end dates, employers, duties performed, etc.):

Legal Status

Present Legal Status:

No legal involvement

Arrested

In jail

Charges pending

On probation

In juvenile detention

Adjudicated

On parole

Referred to juvenile court

Awaiting trial

Awaiting sentencing

On appeal

Pre-trial diversion

Parole Officer name (if applicable): _____

TDCJ# (if applicable): _____

Past Legal Status:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> No legal involvement | <input type="checkbox"/> Arrested | <input type="checkbox"/> In jail | <input type="checkbox"/> In prison/TYC |
| <input type="checkbox"/> On probation | <input type="checkbox"/> In juvenile detention | <input type="checkbox"/> Adjudicated | <input type="checkbox"/> On parole |
| <input type="checkbox"/> Referred to juvenile court | <input type="checkbox"/> Pre-trial diversion | <input type="checkbox"/> Ordered to community service | |

Additional information:

Strengths/Supports and Potential Barriers

Your strengths (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Ability to care for self/others | <input type="checkbox"/> Ability to maintain relationships |
| <input type="checkbox"/> Ability to manage finances | <input type="checkbox"/> Ability to participate in treatment |
| <input type="checkbox"/> Artistic talent | <input type="checkbox"/> Capable of independent living |
| <input type="checkbox"/> Community support/network | <input type="checkbox"/> Complaint with previous treatment |
| <input type="checkbox"/> Education | <input type="checkbox"/> Enjoyment of gardening |
| <input type="checkbox"/> Enjoyment of reading | <input type="checkbox"/> Family support and involvement |
| <input type="checkbox"/> Good verbal/intellectual skills | <input type="checkbox"/> History of adequate decision making |
| <input type="checkbox"/> History of community involvement | <input type="checkbox"/> History of participation in sports |
| <input type="checkbox"/> Insight into problems | <input type="checkbox"/> Interest in hobbies |
| <input type="checkbox"/> Interest in sports | <input type="checkbox"/> Motivated for treatment |
| <input type="checkbox"/> Nurturance and enjoyment of pets | <input type="checkbox"/> Nurturance of children |
| <input type="checkbox"/> Religious affiliation/support network | <input type="checkbox"/> Sense of humor |
| <input type="checkbox"/> Stable work history | <input type="checkbox"/> Support of friends |
| <input type="checkbox"/> Technical/vocational skills | |

Describe any leisure activities or hobbies:

What are your current support systems?

- | | |
|---|--|
| <input type="checkbox"/> Family support and involvement | <input type="checkbox"/> Spouse support and involvement |
| <input type="checkbox"/> Boy/girlfriend | <input type="checkbox"/> Support of friends |
| <input type="checkbox"/> Community involvement | <input type="checkbox"/> Religious affiliation/support network |
| <input type="checkbox"/> Involvement in school activities | <input type="checkbox"/> Participates in organized sports |
| <input type="checkbox"/> Currently employed | <input type="checkbox"/> 12-Step program |
| <input type="checkbox"/> Other support groups | <input type="checkbox"/> Counselor |
| <input type="checkbox"/> Other | |

Describe other:

Potential barriers to treatment:

- | | |
|--|--|
| <input type="checkbox"/> Assaultive behavior | <input type="checkbox"/> Difficulties with interpersonal relationships |
| <input type="checkbox"/> Family difficulties | <input type="checkbox"/> Family history of psychiatric difficulties |
| <input type="checkbox"/> Financial difficulties | <input type="checkbox"/> Frequently blames others |
| <input type="checkbox"/> History of treatment non-compliance | <input type="checkbox"/> Impaired decision making ability |
| <input type="checkbox"/> Inability to care for self/others | <input type="checkbox"/> Lack of family support |
| <input type="checkbox"/> Lack of transportation | <input type="checkbox"/> Learning difficulties |
| <input type="checkbox"/> Legal difficulties | <input type="checkbox"/> Limited attention span |
| <input type="checkbox"/> Limited communication ability | <input type="checkbox"/> Limited education |
| <input type="checkbox"/> Limited intellectual functioning | <input type="checkbox"/> Limited vocational skills |
| <input type="checkbox"/> Little insight into problems | <input type="checkbox"/> Memory impairment |
| <input type="checkbox"/> Physical problems | <input type="checkbox"/> Physical/medical problems |
| <input type="checkbox"/> Poor verbal skills | <input type="checkbox"/> Religious/spiritual/cultural beliefs |
| <input type="checkbox"/> Reluctance to take medication | <input type="checkbox"/> Socially withdrawn |
| <input type="checkbox"/> Substance abuse | <input type="checkbox"/> Unduly suspicious |
| <input type="checkbox"/> Unstable living conditions | |

Explain barriers:

Betty Hardwick Center

AUDIT - C Questionnaire

These questions refer to the past 12 months

1. How often do you have a drink containing alcohol?
 - a. Never
 - b. Monthly or less
 - c. 2-4 times a month
 - d. 2-3 times a week
 - e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?
 - a. 1 or 2
 - b. 3 or 4
 - c. 5 or 6
 - d. 7 or 9
 - e. 10 or more

3. How often do you have six or more drinks on one occasion?
 - a. Never
 - b. Less than monthly
 - c. Monthly
 - d. Weekly
 - e. Daily or almost daily

Total:

Score: a = 0; b = 1; c = 2; d = 3; e = 4

DRUG USE QUESTIONNAIRE (DAST - 10)

Betty Hardwick Center

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then circle the appropriate response beside the question.

In the statements "drug abuse" refers to (1) the use of prescribed or over the counter drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions do not include alcoholic beverages.

Please answer every question if you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months.

- | | | |
|--|-----|----|
| 1. Have you used drugs other than those required for medical reason? | Yes | No |
| 2. Do you abuse more than one drug at a time? | Yes | No |
| 3. Are you always able to stop using drugs when you want to? | Yes | No |
| 4. Have you had "blackouts" or "flashbacks" as a result of drug use? | Yes | No |
| 5. Do you ever feel bad or guilty about your drug use? | Yes | No |
| 6. Does your spouse (or parents) ever complain about your involvement with drugs? | Yes | No |
| 7. Have you neglected your family because of your use of drugs? | Yes | No |
| 8. Have you engaged in illegal activities in order to obtain drugs? | Yes | No |
| 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | Yes | No |
| 10. Have you had medical problems as a result of your drug use (memory, loss, hepatitis, convulsions, bleeding, etc.)? | Yes | No |

FINANCIAL ASSESSMENT QUESTIONNAIRE

1. How many people are in the household? (Your family, spouse and dependents, etc.)
2. Who are the people in the household? Spouse, children, etc.
3. Do you or your spouse work? If so, where at?
4. What is the hourly pay rate?
5. How many hours per week are worked on average?
6. Do you or does anyone in the household receive SSI, SSDI or Retirement benefits? If so, how much and who?
7. Does anyone in the family receive food stamps? If so, how much?
8. Does the family receive HUD housing assistance? If so, how much do they help pay?
9. Have you ever applied for SSI? If so, what was the outcome?
10. Does the client want to apply for SSI benefits?
11. If there is no income in the household, how are the daily needs for the family met?