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 ☐ insominia ☐ 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) O
☐ 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: O yes / O no

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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:

- ☐ Adult Homeless
- ☐ Alone
- ☐ Assisted Living
- ☐ Children Residential Treatment
- ☐ Correctional
- ☐ Crisis Residential
- ☐ Family/Relative
- ☐ Foster Care
- ☐ Group Quarters
- ☐ Independent
- ☐ Institutional Setting
- ☐ Jail/Correctional Facility
- ☐ Medical
- ☐ Other Institutional
- ☐ Residential Care
- ☐ Roommate
- ☐ Treatment Training Services

Number of persons other than you living in the home: _____

You currently live with (check all that apply):

- ☐ Spouse
- ☐ Significant Other
- ☐ Mother
- ☐ Father
- ☐ Guardian
- ☐ Grandparent
- ☐ Uncle
- ☐ Aunt
- ☐ Son
- ☐ Daughter
- ☐ Brother
- ☐ Sister
- ☐ Cousin
- ☐ Foster Parent
- ☐ Friend
- ☐ Other

Current home atmosphere:

- ☐ Loving
- ☐ Comfortable
- ☐ Supportive
- ☐ Chaotic
- ☐ Abusive
- ☐ 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 religous 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:

☐ N/A ☐ Head Start ☐ Pre-Kinder ☐ Kindergarten
☐ 1st Grade ☐ 2nd Grade ☐ 3rd Grade ☐ 4th Grade ☐ 5th Grade
☐ 6th Grade ☐ 7th Grade ☐ 8th Grade
☐ 9th Grade ☐ 10th Grade ☐ 11th Grade ☐ 12th Grade ☐ HS Grad/GED
☐ Some College ☐ B.A./Higher ☐ 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:

- [ ] No legal involvement
- [ ] Arrested
- [ ] In jail
- [ ] In prison/TYC
- [ ] On probation
- [ ] In juvenile detention
- [ ] Adjudicated
- [ ] On parole
- [ ] Referred to juvenile court
- [ ] Pre-trial diversion
- [ ] Ordered to community service

Additional information:

Strengths/Supports and Potential Barriers

Your strengths (check all that apply):

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

Describe any leisure activities or hobbies:

What are your current support systems?

- [ ] Family support and involvement
- [ ] Boy/girlfriend
- [ ] Community involvement
- [ ] Involvement in school activities
- [ ] Currently employed
- [ ] Other support groups
- [ ] Other
- [ ] Spouse support and involvement
- [ ] Support of friends
- [ ] Religious affiliation/support network
- [ ] Participates in organized sports
- [ ] 12-Step program
- [ ] Counselor

Describe other:

Potential barriers to treatment:

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

Explain barriers:

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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)

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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, tranquillizers (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?