Missouri Ozarks Community Health

CHILD/ADOLESCENT PERSONAL HISTORY

(AGES 17 AND UNDER)

CHILD'S HISTORY: To be completed by parent or guardian. In order for our professionals to serve you better, please answer the following questions and return this form prior to your appointment, or you may bring it with you. Feel free to add any extra comments on a separate sheet. If there are any questions you can not, or choose to not answer, please leave them blank. Your child's counselor will review the form with you. Thank you!

Today's date _____ Name of Child _____
Birthdate _____ School _____ Grade ____ Teacher _____
Your name and relationship to child _____
Name of child's legal guardian(s) _____
Who referred you to Missouri Ozarks Community Health Mental Health Program? _____

	NAME	AGE
Child's Parents:		
Step-parents:		
Child's Siblings: B=Brother S=Sister SB=Step-brother SS=Step-sister HB=Half-brother HS=Half-sister (If any of above are deceased, put a "D" and year in the Age column.) Example: D1987	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____

Child is being raised by: _____

Who lives in child's main household? _____

_____

CONCERNS

What are the main concerns you have about your child? _____

_____

_____

A. When did you first notice the problem? _____
B. Why do you think your child is having problems? _____
C. Who else have you seen for this problem? _____
D. What has already been done to treat this problem (diet, medications, counseling, evaluations)? _____
_____
E. What have you done, personally, to address the problem? _____
_____
F. What seems to help the most? _____
G. What would you or referring person like to see done for your child? _____

PREGNANCY AND BIRTH

1. Was the pregnancy
   a) planned? Yes _____ No _____
   b) welcomed? Yes _____ No _____
   c) stressful? Yes _____ No _____
2. Where there any medical concerns or other issues during this pregnancy regarding mother and/or baby?

   _____

   _____
3. Is your child adopted? ____ Does he/she know? ____ If not, do you intend to tell him/her? _____
   At what age was the child placed in your home _____ At what age was the child adopted? _____

HEALTH

1. Has your child had any of the following? (please circle all that apply):

measles	mumps	chicken pox	whooping cough
pneumonia	encephalitis	meningitis	ear infections
lead poisoning	allergies	vision problems	hearing problems

2. Does your child have any chronic medical problems? No ___ Yes, Please explain: _____

   _____

   _____
3. Does your child experience problems related to sleep? No ___ Yes, Please explain: _____

   _____
4. Has your child ever been hospitalized? If so, explain each hospitalization, including ages, reasons, and length of stay: _____

   _____

   _____

   _____
5. Has your child ever taken medication to help with behavior or emotional problems?

   Age Medicine Doctor Reason When/Why stopped?

   _____

   _____

   _____
6. Does child have any food or medication allergies? Yes ____ No ____ If yes, please list _____

   _____
7. Have you ever suspected that this child might have been physically or sexually abused? Yes ___ No ___
   If yes, please explain: _____

   _____
8. Child's current appetite? _____ Does child over-eat? _____ Refuse food? _____ Purge? _____
9. Is your child's immunizations up-to-date? Yes ____ No ____
10. Describe any recent weight gain or loss: _____

    _____
11. Describe child's usual energy/activity level: _____

    _____

DEVELOPMENT

1. Early development

A. At about what age did your child first:

	Age	Not sure of age, but: Early	On Time	Late
Smile, goo and coo?	____	____	____	____
Sit up?	____	____	____	____
Crawl?	____	____	____	____
Stand alone?	____	____	____	____
Speak real words?	____	____	____	____
Walk by self?	____	____	____	____
Feed self?	____	____	____	____
Use two word sentences?	____	____	____	____
Dress self? (except buttoning and tying)	____	____	____	____
Speak so that strangers understood?	____	____	____	____
Ride a tricycle?	____	____	____	____
Ride a bicycle?	____	____	____	____
Tie own shoe?	____	____	____	____

B. Describe child as an infant/toddler. Please circle

cheerful	fussy
cuddly	withdrawn
independent	clingy
_____	_____

C. Describe any early parent/child separations: _____

_____

_____

D. Have you ever been concerned or been told that your child's development (speech and language, coordination, growth or social abilities) was behind his/her peers? _____

_____

SCHOOL

Name of School _____ Phone _____

Teacher name _____ Grade _____

1. What is your impression of your child's learning potential? Please circle:
   Low average above average gifted

2. Do you feel that your child is performing up to his/her potential in school? Yes ____ No ____

3. When did school performance/behavior change? _____

4. Why do you think it changed? _____

5. Do you feel that your child has any difficulties with (circle any that apply and explain)?
   Reading _____
   Writing _____
   Arithmetic _____
   Social Studies _____
   Science _____
   Languages _____

6. Is homework a problem? If so, please circle all that apply:

can't get started	no place to work
forgets to bring home materials	forgets assignments
doesn't understand the work	doesn't anticipate deadlines
distracted by radio, TV or anything	takes too long
battles or argues about doing work	the most stressful time of day
needs you there constantly	doesn't care/no motivation

7. Is your child's work made more difficult by problems with:

	Not at all	Somewhat	A lot
poor concentration	_____	_____	_____
giving up too easily	_____	_____	_____
inconsistent performance	_____	_____	_____
poor motivation	_____	_____	_____
disorganization	_____	_____	_____
spacing out or daydreaming	_____	_____	_____
not finishing things	_____	_____	_____
having low frustration tolerance	_____	_____	_____
anxiety/sadness	_____	_____	_____
poor handwriting	_____	_____	_____
rapidly shifting from one thing to another	_____	_____	_____
being easily distracted	_____	_____	_____
impulsiveness	_____	_____	_____
anxious	_____	_____	_____

8. Has your child ever been retained _____ suspended _____ expelled ____ advanced a grade _____?

9. Education of each parent/guardian: _____

10. Employment/training hours of each parent/guardian: _____
_____

SOCIAL

Does your child get along well with others? In what areas do you notice difficulties? Please answer **yes, no** or **sometimes** to the following. You may add comments.

makes friends easily _____
has a best friend _____
plays well with others _____
shares easily _____
follows rules _____
enjoys team sports _____
leads other children _____
helps others _____
easily influenced _____
prefers to be alone _____
is a party animal _____
bullies others _____
fights others _____
insists on having his own way _____

SELF-ESTEEM

Does your child (please circle):

have an "I can do it" attitude?	Yes No	give up easily?	Yes No
recover from upsets?	Yes No	stand up for self?	Yes No
recognize strengths?	Yes No	lack confidence?	Yes No
		act adventuresome?	Yes No

FAMILY

1. Are you satisfied with how your family works? Please circle any that might apply:

lack of structure; rules	no family "together times"
poor communication	financial troubles
poor division of chores, responsibilities	lack of "breathing space"
marital problems	resentment of another member

Comments: _____

2. Where and how does this child fit into the family? Please circle any that apply:

sibling rivalry (more than expected)	a team player
spoiled, always gets own way	a manipulator
a rescuer, can't stand upsets	a helper

Born baby # _____ out of _____ children.

3. What responsibilities/chores does this child have in the family? Rate how they handle them: U=unsatisfactory; S=satisfactory; E=excellent

___make bed	___set the table
___pick up after self	___take out the trash
___feed/water the pet	___wash dishes
___ _____	___ _____

4. What types of discipline are used in your family? Use **M** to indicate which ones mother uses, **F** to indicate which ones father uses:

___discussion and education	___positive reward and praise
___encouraging independent thinking	___time out
___contracts/token systems	___spanking
___lecturing, nagging, yelling	___restriction/grounding

For what is your child most frequently disciplined? _____

What type of discipline(s) work best with your child? _____

_____

5. Please circle any of the following stressors which might apply to your family's situation, or to which the child had an extremely strong reaction. Please note how long ago the stressor occurred:

parental separation/divorce	severe illness
death of a family member/important friend	move to a new house
change in school	change of job
financial stress	pregnancy/birth of new child

Comments: _____

_____

_____

6. Please circle your current marital status: married single divorced widowed live together

7. If divorced from biological parent, what are the custody arrangements (legal and physical, please)?

_____

_____

_____

8. If divorced, what is the non-custodial parent's involvement with this evaluation? _____

_____

9. What are the names and ages and relationship of other children living at the home? _____

_____

10. Is there any family history of medical, developmental, learning, psychiatric, or legal difficulties?

Yes ____ No ____ If yes, please list the individual's relationship to the child, the nature of each difficulty, and any treatments received. Please include past generations and extended family if you have such information: _____

_____

_____

_____

11. Please describe any psychiatric or psychological treatment this child or any sibling has received:

_____

_____

_____

12. Please review each of the following lists of characteristics and check any item that applies to your child:

A. Does your child have any of the following attention related troubles?

___fidgets
___easily distracted
___difficulty playing quietly
___shifts from one activity to another
___often interrupts or intrudes on others
___often engages in physically dangerous activities
___often blurts out answers to questions before completed
___difficulty remaining seated
___difficulty waiting turn
___difficulty sustaining attention
___often does not listen
___often loses things
___difficulty following instructions
___often talks excessively

B. Does your child have any of the following oppositional troubles?

___often deliberately acts to annoy others
___is often touchy or annoyed by others
___often swears/uses obscene language
___often blames others for own mistakes
___often actively defies or refuses adult requests of rules
___often takes or touches others' property without asking
___often argues with adults
___is often angry or resentful
___is often spiteful or vindictive
___often loses temper

C. Has your child had problems with any of the following?

___stolen without confrontation
___deliberate fire setting
___breaking and entering
___cruel to animals
___forced someone else into sexual activity
___often initiates physical fights
___lies often
___often truant from school
___destroyed others' property
___used a weapon in a fight
___stolen with confrontation
___physically cruel to people

D. Does your child show any of the following anxiety symptoms?

___unrealistic worry about future events
___persistent refusal to go to school
___bothersome thoughts
___unrealistic concerns about competence
___repeated nightmares about separation from you
___excessive distress when separated from home or from you
___unrealistic and persistent worry that something will happen to you
___avoidance of being alone
___physical aches and pains
___marked self consciousness
___marked inability to relax
___ongoing refusal to sleep alone
___excessive need for reassurance

E. Does your child show:

___diminished pleasure in activities
___depressed or irritable mood most of the day, nearly every day
___poor appetite or overeating
___trouble sleeping or sleeping too much
___feelings of worthlessness or excessive inappropriate guilt
___suicidal thoughts or actions
___low self esteem
___agitation or sluggishness
___low energy or fatigue
___poor concentration

F. Does your child have any of the following sensory symptoms?

___repeated unusual movements
___compulsive rituals
___vocal tics
___excessive reaction to noise or failing to react to loud noises
___odd postures
___motor tics
___overreacts to touch

G. Has your child exhibited any symptoms of thought disturbance, including any of the following?

___can't get to the point, loses train of thought
___bizarre ideas (odd fascinations, strange ideas, hallucinations)
___disoriented, confused, staring or "spacey"
___incoherent speech (mumbles, uses words only the child understands)

H. Has your child exhibited symptoms of affective mood disturbance, including any of these?

___explosive temper with little provocation
___excessively monotonous or bland affect
___situationally inappropriate emotions
___excessive reaction to changes in routine
___unusual fears
___panic attacks
___excessive mood swings

Comments regarding any of the above items which you checked: _____

_____

_____

_____

If child DRINKS or uses DRUGS, please list type (including alcohol, non prescribed drugs, nicotine or caffeine), frequency (daily, weekly, monthly, etc), and amount used. If your child does not drink or use drugs, please list N/A for not applicable.

_____

_____

_____

_____

_____

STRENGTHS:

Please tell us about your child's most outstanding characteristics, hobbies, achievements, abilities, etc.:

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire. We know it is long and time consuming, but it really helps us to serve you and your child better. If you can return it to us prior to your visit, we will review what you have shared with us in order to better focus on your concerns. This information, as all Missouri Ozarks Community Health medical records, is strictly confidential. It will not be released to anyone without your written permission.

Therapist/Credentials: _____ Date: _____

Client Name: _____ Birthdate: _____ Pt. ID #: _____ Date: _____ Pg. ____