Child/Adolescent Social History

Client Name (First, MI, Last)	**Date of Birth**	**Today's Date**

Presenting Problem

What are the 2-3 primary reasons you are seeking counseling/therapy today for your child/adolescent?

How long ago did you begin to be troubled by this problem?

List three (3) goals you would like to accomplish by attending counseling:

Is this the first time you've seen a therapist/counselor for these issues?

If you have been in counseling before, please explain how previous counseling helped and/or didn't help you with these issues.

Symptom Checklist

Check All Current Problems

☐ **Nutritional/Eating Pattern Changes/Disorders**

As evidenced by:

☐ Self-induced Vomiting	☐ Increase in Appetite	☐ Weight Gain
☐ Binge Eating	☐ Decrease in Appetite	☐ Weight Loss
☐ Use of Laxatives	☐ Excessive Exercising	☐ None

☐ **Pain Management**

As evidenced by:

☐ Pain Interferes with Activities	☐ None

☐ **Depressed Mood/Sad**

As evidenced by:

☐ Loss of Interest in Activities	☐ Hopelessness	☐ Indecisiveness
☐ Empty Feeling	☐ Worthlessness	☐ Recurrent Thoughts of Death
☐ Fatigue/Loss of Energy	☐ Trouble Concentrating	☐ Feeling Sad or Depressed
☐ Thoughts of Harming Yourself	☐ None	

☐ **Grief Issues**

As evidenced by:

☐ Loss of Loved One in Past Year	☐ Other Loss (Describe)	☐ None

Client Name (First, MI, Last)	**Date of Birth**

☐ **Anxiety**

As evidenced by:

☐ Excessive Worry ☐ Irritability ☐ Excessive Checking
☐ Restlessness ☐ Compulsions ☐ Strong Fears
☐ Obsessions ☐ Difficulty Breathing ☐ Shaking
☐ Muscle Tension ☐ Pounding Heart ☐ Excessive Handwashing
☐ None

☐ **Traumatic Stress**

As evidenced by:

☐ Recurrent/Intrusive/Distressing Thoughts/Images ☐ Startles Easily ☐ None
☐ Recurrent Dreams/Nightmares ☐ Exposure to Traumatic Event

☐ **Anger/Aggression**

As evidenced by:

☐ Threatens/Intimidates Others ☐ Physically Hurts People ☐ Use of Weapons
☐ Initiates Fights ☐ Physically Hurts Animals ☐ None

☐ **Oppositional Behaviors**

As evidenced by:

☐ Loses Temper ☐ Blames Others ☐ Spiteful/Vindictive
☐ Argues ☐ Easily Annoyed ☐ None
☐ Deliberately Annoys Others ☐ Angry and Resentful

☐ **Inattention**

As evidenced by:

☐ Difficulty Sustaining Attention ☐ Disorganized ☐ Forgetful
☐ Trouble Finishing Things ☐ Easily Distracted ☐ None

☐ **Impulsivity**

As evidenced by:

☐ Difficulty Resisting Impulses ☐ Trouble Waiting for Turn ☐ Frequently Interrupts
☐ None

☐ **Disturbed Reality Contact**

As evidenced by:

☐ Hears Voices Others Don't Hear ☐ Seeing Things Others Don't See ☐ None

☐ **Mood Swings/Hyperactivity**

As evidenced by:

☐ Excessive Movement ☐ Excessive Talking ☐ Rapid or Extreme Changes in Mood
☐ Decreased Need for Sleep ☐ Irritability ☐ Inflated Self-Esteem
☐ None

☐ **Addictive Behaviors**

As evidenced by:

☐ Gambling ☐ Internet ☐ Shopping
☐ Pornography ☐ None

Client Name (First, MI, Last)	**Date of Birth**

☐ **Sleep Problems**
As evidenced by:

☐ Difficulty Falling or Staying Asleep ☐ Sleepwalking ☐ Frequent Nightmares
☐ Excessive Sleepiness ☐ None

☐ **Wetting or Soiling**
As evidenced by:

☐ Daytime ☐ Nighttime ☐ None

☐ **Stressors**

☐ **Other**
As evidenced by:

☐ Obsessions ☐ Compulsions ☐ Other:

Pertinent Developmental Issues

Mother's Pregnancy History (include prenatal exposure to alcohol, tobacco, and other drugs)
☐ No Problems Reported

Infancy (Ages 0-1)
☐ No Problems Reported

Preschool (Ages 2-4)
☐ No Problems Reported

Childhood (Ages 5-12)
☐ No Problems Reported

Adolescent (Ages 13-17)
☐ No Problems Reported

Client Name (First, MI, Last)	**Date of Birth**

Living Situation

Parent's Home

☐ Rent ☐ Own

****Residential Care/Treatment Facility**

☐ Hospital ☐ Temporary Housing ☐ Residential Care ☐ Nursing Home

****Other**

☐ Friend's Home ☐ Relative's/Guardian's Home ☐ Foster Care Home ☐ Respite Care

☐ Homeless Living with Friend ☐ Homeless in Shelter/No Residence ☐ Jail/Prison ☐ Other:

****Identify Facility or Person's Name**

Primary Household

Household Member Names	Relationship To Client	Age	Occupation/School	Level of Education	Quality of Relationship (Staff Use Only)

Secondary Household

Does client live in more than one household?

☐ No If no, skip to "Additional Family Members"

☐ Yes If yes, complete the secondary household information below

Household Member Names	Relationship To Client	Age	Occupation/School	Level of Education	Quality of Relationship (Staff Use Only)

Secondary Household Street Address (if different from client's address listed on Demographic Information Form)

Family Members Who Live in Both Households

☐ Client only ☐ Client and (List):

Additional Family Members (i.e., parents or siblings not living in primary or secondary households)

☐ No parents or siblings other than those listed in primary or secondary households

Custody and Parenting Plan

☐ Lives with both parents (biological or adoptive) in same household or with widowed parent

☐ Other (describe):

Client Name (First, MI, Last)	**Date of Birth**

Family Environment/Relationships

Parent-Child (Client) Relationship(s): ☐ Not Applicable P = Primary Household S = Secondary Household B = Both

Comment on Parent-Child Relationship(s): (could include parent-child conflict, parent supervision and monitoring of child, cooperation between parents regarding child rearing, parent positive activities with child, parent satisfaction with relationship, child satisfaction with relationship(s))

Sibling-Child (Client) Relationship(s): ☐ No Siblings P = Primary Household S = Secondary Household B = Both

Comment on Sibling-Child Relationship(s): (could include sibling-child conflict, positive activities with child, sibling satisfaction with relationship, child satisfaction with relationship(s))

Parent Marital or Couples Relationship(s): ☐ Not Applicable at this time P = Primary Household S = Secondary Household B = Both

Comment on Parent Marital or Couples Relationship(s): (could include marital or couples conflict, marital or couples satisfaction with relationship(s))

Family Concerns

			If yes, indicate relationship to child:
Family Member Alcohol Abuse:	☐ No	☐ Yes	
Family Member Drug Abuse:	☐ No	☐ Yes	
Family Member Mental Health Problems:	☐ No	☐ Yes	
Family Member Health Problems:	☐ No	☐ Yes	
Family Member Disability:	☐ No	☐ Yes	
Family Member Legal Issues:	☐ No	☐ Yes	
Family Member Financial Concerns	☐ No	☐ Yes	

Other (describe)

Comment on other family concerns and information relating to financial status (specify problems that impact client's needs)

Client Name (First, MI, Last)	**Date of Birth**

School Functioning

Educational Classification

Name of School:	Current Grade:

Regular Education Classification, No Special Services

☐ Yes ☐ No If no, check all that apply

☐ 01 Multiple disabilities (not deaf-blind)	☐ 06 Orthopedic Impairment	☐ 11 Autism
☐ 02 Deaf-Blindness	☐ 07 Emotional Disturbance (SBH)	☐ 12 Traumatic Brain Injury
☐ 03 Deafness (hearing impairment)	☐ 08 Mental Retardation (DH)	☐ 13 Other Health Impaired (Major)
☐ 04 Visual Impairment	☐ 09 Specific Learning Disability	☐ 14 Other Health Impaired (Minor)
☐ 05 Speech or Language Impairment	☐ 10 Preschoolers with a Disability	☐ 15 Current 504 Plan
☐ Other:		

Comments on Educational Classification/Placement (please indicate if client is home schooled, in gifted program, etc.)

Grades

School Proficiency/Achievement Exams/Ohio Graduation Tests (OGT)

Most Recent Exams: Grade level taken _____ ☐ OGT (reading and math only) ☐ Has not taken these exams

Exams Taken	Results		
Reading	☐ Passed	☐ Did Not Pass	☐ Unknown
Math	☐ Passed	☐ Did Not Pass	☐ Unknown
Citizenship	☐ Passed	☐ Did Not Pass	☐ Unknown or N/A
Science	☐ Passed	☐ Did Not Pass	☐ Unknown or N/A
Writing	☐ Passed	☐ Did Not Pass	☐ Unknown or N/A

Other Test Results (IQ, Achievement, Developmental)

☐ No other test results reported

Attendance

☐ Not a problem

Previous Grade Retentions

☐ None reported

Client Name (First, MI, Last)	**Date of Birth**

Suspensions/Expulsions

☐ None reported

Other Academic School Concerns (including performance/behavioral problems due to AOD use)

☐ None reported

Barriers to Learning

☐ None reported ☐ Inability to Read or Write ☐ Other:

Peer Relationships/Social Functioning

Special Communication Needs

☐ None reported ☐ TDD/TTY Device ☐ Sign Language Interpreter ☐ Assistive Listening Device(s)

☐ Language Interpreter Services Needed/Other Spoken Language: _____

☐ Other: _____

Employment

☐ Not Pertinent – Skip this section

Currently Employed? ☐ Yes ☐ No If yes, name of employer

Name of Employer: Job Title:

Employment Interests/Skills/Concerns

Client Name (First, MI, Last)	**Date of Birth**

Legal History

Current Legal Status

☐ None Reported ☐ On Probation ☐ Detention ☐ On Parole

☐ AoD Related Legal Problems ☐ Awaiting Charge ☐ Court Ordered to Treatment ☐ Others

History of Legal Charges

☐ No ☐ Yes If yes, check and describe ☐ Status Offense (e.g., Unruly)

☐ Delinquency

Name of Probation/Parole Officer (if applicable)

Adjudications

☐ No ☐ Yes If yes, describe:

Detentions or Incarcerations

☐ No ☐ Yes If yes, describe:

Civil Proceedings

☐ No ☐ Yes If yes, describe:

Domestic Relations Court Involvement

☐ No ☐ Yes If yes, describe:

Juvenile Court Involvement (related to child abuse, neglect, or dependency)	**Caseworker Name** (if applicable)
Current: ☐ No ☐ Yes Comment: _____	
Past: ☐ No ☐ Yes Comment: _____	

Children's Protective Services Involvement with Family

☐ No ☐ Yes If yes, describe:

Name of Children's Protective Services Caseworker(s) Assigned to Family (if applicable)

☐ None Reported

Name of Guardian ad Litem (GAL) or Court Appointed Special Advocate (CASA) Assigned to Family (if applicable)

☐ None Reported

Client Name (First, MI, Last)	**Staff Use Only: Client Number**	**Date of Birth**

Child/Adolescent Health History Questionnaire

This form should be completed as fully as possible by client, but reviewed by medical or clinical staff

Has the child had any of the following health problems?

	Now	Past	Never	What Treatment Was Received and Date(s)
Anemia				
Arthritis				
Asthma				
Bleeding Disorder				
Blood Pressure (high or low)				
Bone/Joint Problems				
Cancer				
Cirrhosis/Liver Disease				
Diabetes				
Epilepsy/Seizures				
Eye Disease/Blindness				
Fibromyalgia/Muscle Pain				
Glaucoma				
Headaches				
Head Injury/Brain Tumor				
Hearing Problems/Deafness				
Heart Disease				
Hepatitis/Jaundice				
Kidney Disease				
Lung Disease				
Menstrual Pain				
Oral Health/Dental				
Stomach/Bowel Problems				
Stroke				
Thyroid				
Tuberculosis				
AIDS/HIV				
Sexually Transmitted Disease				
Learning Problems				
Speech Problems				
Anxiety				
Bipolar Disorder				
Depression				
Eating Disorder				
Hyperactivity/ADD				
Schizophrenia				
Sexual Problems				
Sleep Disorder				
Suicide Attempts/Thoughts				
Other:				
Other:				

Please note family history of any of the above conditions and client's relationship to that family member

Client Name (First, MI, Last)	**Date of Birth**

Current Medication Information

(medical and psychiatric prescription/OTC/herbal)

☐ None Reported

Medication	Rationale	Dosage/Route/Frequency	Staff Use Only: Compliance			
			Yes	No	Partial	Unk

Primary Care Physician (name, phone no., and address)	**Date of Last Physical Exam**

Other Prescribing Physician(s) (name, phone no., and address)

Past Psychiatric Medications

☐ None Reported

Past Psychiatric Medications	Reason for Stopping

Has the child had medical hospitalization/surgical procedures in the last 3 years?

☐ No ☐ Yes If yes, complete information below

Hospital	City	Date	Reason

Allergies/Drug Sensitivities

☐ None
☐ Food (specify)
☐ Medicine (specify)
☐ Other (specify)

Pregnancy History ☐ Not Pertinent

Currently Pregnant? (If yes, expected delivery date)	**Receiving Prenatal Healthcare?** (If yes, indicate provider)
☐ No ☐ Yes Expected Delivery Date	☐ No ☐ Yes Provider
Currently Breastfeeding? ☐ No ☐ Yes	
Last Menstrual Period Date	**Any Significant Pregnancy History?** (if yes, explain) ☐ No ☐ Yes

Client Name (First, MI, Last)	**Date of Birth**

Medical Information

Last Physical Examination

By Whom: Date: Phone No.(if known):

Indicate how many times in the past 12 months the child has used these medical services:

_____ Hospital admissions _____ Emergency room visits

_____ Regular visits to doctor _____ Regular visits to dentist

Has the child had any of the following symptoms in the past 60 days? (please check all that apply)

☐ Ankle Swelling	☐ Diarrhea	☐ Nervousness	☐ Tingling in Arms and/or Legs
☐ Bed wetting	☐ Dizziness	☐ Nosebleeds	☐ Tremor
☐ Blood in Stool	☐ Falling	☐ Numbness	☐ Urination Difficulty
☐ Breathing Difficulty	☐ Gait Unsteadiness	☐ Panic Attacks	☐ Vaginal Discharge
☐ Chest Pain	☐ Hair Change	☐ Penile Discharge	☐ Vision Changes
☐ Confusion	☐ Hearing Loss	☐ Pulse Irregularity	☐ Vomiting
☐ Consciousness Loss	☐ Lightheadedness	☐ Seizures	☐ Other:
☐ Constipation	☐ Memory Problems	☐ Shakiness	
☐ Coughing	☐ Mole/Wart Changes	☐ Sleep Problems	☐ Other:
☐ Cramps	☐ Muscle Weakness	☐ Sweats (night)	

Immunizations – Has the child had or been immunized for the following diseases? (please check all that apply)

☐ Chicken Pox	☐ Diphtheria	☐ German Measles	☐ Hepatitis B	☐ Measles
☐ Mumps	☐ Polio	☐ Small Pox	☐ Tetanus	☐ Other:

Immunizations Within the Past Year

Height	**Has client's weight changed in the past year?**
Weight	☐ No ☐ Yes If yes, by how much (+ or -): _____

Nutritional Screening

No Problem	**Eating**	**Drinking**	**Appetite**
☐	☐ More ☐ Less ☐ Not Eating	☐ More ☐ Less ☐ Takes Liquids Only	☐ Increased ☐ Decreased

☐ Nausea ☐ Vomiting ☐ Trouble Chewing or Swallowing

Special Diet	**Other**

Client Name (First, MI, Last)	**Date of Birth**

Pain Screening

Does pain currently interfere with the child's activities? (if yes, how much does it interfere with these activities [please check])

☐ No ☐ Yes ☐ Not at all ☐ Mildly ☐ Moderately ☐ Severely ☐ Extremely

Please indicate the source of the pain

Substance Use History/Current Use

(Please check and complete appropriate columns)

Which of the following has the child used?	Age first used	Age last used	Frequency of use
☐ Beer			
☐ Wine			
☐ Liquor			
☐ Heroin			
☐ Barbiturates			
☐ Amphetamines			
☐ Crack			
☐ Cocaine			
☐ Marijuana/Hashish			
☐ LSD			
☐ Inhalants			
☐ PCP			
☐ MDMA (XTC)			
☐ Prescription drugs off the street			
☐ Non-prescription drugs by injection			
☐ Other			

Caffeine	Nicotine
_____ Cups of caffeinated coffee per day	_____ Packs of cigarettes per day
_____ Cups of caffeinated tea per day	_____ Other nicotine products per day
_____ Cups of caffeinated soft drinks per day	_____ Other Use:
_____ Ounces of chocolate per day	

Print Name of Person Completing This Questionnaire	Signature of Person Completing This Questionnaire	Date

Clinician Reviewer Comment (if any) ☐ Medical Review Needed

Print Name of Clinician	Signature of Clinician	Date

Client Name (First, MI, Last)	**Date of Birth**

Comments, Recommendations or Referrals by Medical Reviewer

Check Referral(s) Needed and Specify Action(s)

☐ No Referral Needed

☐ Primary Care Physician:

☐ Healthcare Agency:

☐ Specialty Care:

☐ Other (specify):

Recommendations shared with client?

☐ No ☐ Yes If yes, client's response:

If no, how will recommendations be shared with client?

Medical Reviewer Signature/Credentials (Nurse, PA, NP, MD, DO)	**Date**
Client Signature	**Date**
Clinician Reviewing	**Date**