**Child/Adolescent Social History**

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| **Client Name** (First, MI, Last)Click here to enter text. | **Date of Birth**Click here to enter a date. | **Today’s Date**Click here to enter a date. |
| **Presenting Problem** |
| What are the 2-3 primary reasons you are seeking counseling/therapy today for your child/adolescent?1. Click here to enter text.
 |
| How long ago did you begin to be troubled by this problem?Click here to enter text. |
| List three (3) goals you would like to accomplish by attending counseling:1.Click here to enter text.2.Click here to enter text.3.Click here to enter text. |
| Is this the first time you’ve seen a therapist/counselor for these issues? [ ] Yes [ ] NoIf you have been in counseling before, please explain how previous counseling helped and/or didn’t help you with these issues.Click here to enter text. |
| **Symptom Checklist**Check All Current Problems |
| [ ]  **Nutritional/Eating Pattern Changes/Disorders** |
|  | As evidenced by:[ ]  Self-induced Vomiting[ ]  Binge Eating[ ]  Use of Laxatives | [ ]  Increase in Appetite[ ]  Decrease in Appetite[ ]  Excessive Exercising | [ ]  Weight Gain[ ]  Weight Loss[ ]  None |
| [ ]  **Pain Management** |
|  | As evidenced by:[ ]  Pain Interferes with Activities | [ ]  None |  |
| [ ]  **Depressed Mood/Sad** |
|  | As evidenced by:[ ]  Loss of Interest in Activities[ ]  Empty Feeling[ ]  Fatigue/Loss of Energy[ ]  Thoughts of Harming Yourself | [ ]  Hopelessness[ ]  Worthlessness[ ]  Trouble Concentrating[ ]  None | [ ]  Indecisiveness[ ]  Recurrent Thoughts of Death[ ]  Feeling Sad or Depressed |
| [ ]  **Grief Issues** |
|  | As evidenced by:[ ]  Loss of Loved One in Past Year | [ ]  Other Loss (Describe)Click here to enter text. | [ ]  None |

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| **Client Name** (First, MI, Last)Click here to enter text. | **Date of Birth**Click here to enter text. |
| [ ]  **Anxiety** |
|  | As evidenced by:[ ]  Excessive Worry[ ]  Restlessness[ ]  Obsessions[ ]  Muscle Tension[ ]  None | [ ]  Irritability[ ]  Compulsions[ ]  Difficulty Breathing[ ]  Pounding Heart | [ ]  Excessive Checking[ ]  Strong Fears[ ]  Shaking[ ]  Excessive Hand washing |
| [ ]  **Traumatic Stress** |
|  | As evidenced by:[ ]  Recurrent/Intrusive/Distressing Thoughts/Images [ ]  Recurrent Dreams/Nightmares |  [ ]  Startles Easily [ ] Exposure to Traumatic Event | [ ]  None |
| [ ]  **Anger/Aggression** |
|  | As evidenced by:[ ]  Threatens/Intimidates Others[ ]  Initiates Fights | [ ]  Physically Hurts People[ ]  Physically Hurts Animals | [ ]  Use of Weapons[ ]  None |
| [ ]  **Oppositional Behaviors** |
|  | As evidenced by:[ ]  Loses Temper[ ]  Argues[ ]  Deliberately Annoys Others | [ ]  Blames Others[ ]  Easily Annoyed[ ]  Angry and Resentful | [ ]  Spiteful/Vindictive[ ]  None |
| [ ]  **Inattention** |
|  | As evidenced by:[ ]  Difficulty Sustaining Attention[ ]  Trouble Finishing Things | [ ]  Disorganized[ ]  Easily Distracted | [ ]  Forgetful[ ]  None |
|  **Impulsivity** |
|  | As evidenced by:[ ]  Difficulty Resisting Impulses[ ]  None | [ ]  Trouble Waiting for Turn | [ ]  Frequently Interrupts |
| [ ]  **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[ ]  Decreased Need for Sleep[ ]  None | [ ]  Excessive Talking[ ]  Irritability | [ ]  Rapid or Extreme Changes in Mood[ ]  Inflated Self-Esteem |
| [ ]  **Addictive Behaviors** |
|  | As evidenced by:[ ]  Gambling[ ]  Pornography | [ ]  Internet[ ]  None | [ ]  Shopping |

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| **Client Name** (First, MI, Last)Click here to enter text. | **Date of Birth**Click here to enter text. |
| [ ]  **Sleep Problems** |
|  | As evidenced by:[ ]  Difficulty Falling or Staying Asleep[ ]  Excessive Sleepiness | [ ]  Sleepwalking[ ]  None | [ ]  Frequent Nightmares |
| [ ]  **Wetting or Soiling** |
|  | As evidenced by:[ ]  Daytime | [ ]  Nighttime | [ ]  None |
| [ ]  **Stressors** |
| Click here to enter text. |
| [ ]  **Other** |
|  | As evidenced by:[ ]  Obsessions | [ ]  Compulsions | [ ]  Other: Click here to enter text. |
| **Pertinent Developmental Issues** |
| **Mother’s Pregnancy History** (include prenatal exposure to alcohol, tobacco, and other drugs) |
|  | [ ]  No Problems ReportedClick here to enter text. |
| **Infancy (Ages 0-1)** |
|  | [ ]  No Problems ReportedClick here to enter text. |
| **Preschool (Ages 2-4)** |
|  | [ ]  No Problems ReportedClick here to enter text. |
| **Childhood (Ages 5-12)** |
|  | [ ]  No Problems ReportedClick here to enter text. |
| **Adolescent (Ages 13-17)** |
|  | [ ]  No Problems ReportedClick here to enter text. |

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| **Client Name** (First, MI, Last)Click here to enter text. | **Date of Birth**Click here to enter text. |
| **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: Click here to enter text. |
| **\*\*Identify Facility or Person’s Name**Click here to enter text. |
| **Primary Household** |
| Household Member Names | RelationshipTo Client | Age | Occupation/School | Level ofEducation | Quality of Relationship (Staff Use Only) |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
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| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **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 | RelationshipTo Client | Age | Occupation/School | Level ofEducation | Quality of Relationship (Staff Use Only) |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Secondary Household Street Address** (if different from client’s address listed on Demographic Information Form)Click here to enter text. |
| **Family Members Who Live in Both Households** [ ]  Client only [ ]  Client and (List): Click here to enter text. |
| **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 householdsClick here to enter text. |
| **Custody and Parenting Plan** [ ]  Lives with both parents (biological or adoptive) in same household or with widowed parent [ ]  Other (describe): Click here to enter text. |

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| **Client Name** (First, MI, Last)Click here to enter text. | **Date of Birth**Click here to enter text. |
| **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))Click here to enter text. |
| **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))Click here to enter text. |
| **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))Click here to enter text. |
| **Family Concerns** |
|  | **If yes, indicate relationship to child:** |
| Family Member Alcohol Abuse: [ ]  No [ ]  Yes | Click here to enter text. |
| Family Member Drug Abuse: [ ]  No [ ]  Yes | Click here to enter text. |
| Family Member Mental Health Problems: [ ]  No [ ]  Yes | Click here to enter text. |
| Family Member Health Problems: [ ]  No [ ]  Yes | Click here to enter text. |
| Family Member Disability: [ ]  No [ ]  Yes | Click here to enter text. |
| Family Member Legal Issues: [ ]  No [ ]  Yes | Click here to enter text. |
| Family Member Financial Concerns [ ]  No [ ]  Yes | Click here to enter text. |
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| **Other** (describe)Click here to enter text. |
| **Comment on other family concerns and information relating to financial status** (specify problems that impact client’s needs)Click here to enter text. |

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| **Client Name** (First, MI, Last)Click here to enter text. | **Date of Birth**Click here to enter text. |
| **School Functioning** |
| **Educational Classification** |
| Name of School: Click here to enter text. | Current Grade: Click here to enter text. |
| 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: Click here to enter text. |
| **Comments on Educational Classification/Placement** (please indicate if client is home schooled, in gifted program, etc.)  |
| **Grades**Click here to enter text. |
| **School Proficiency/Achievement Exams/Ohio Graduation Tests (OGT)****Most Recent Exams:** Grade level taken Click here to enter text. [ ]  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 reportedClick here to enter text. |
| **Attendance**  [ ]  Not a problemClick here to enter text. |
| **Previous Grade Retentions** [ ]  None reportedClick here to enter text. |

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| **Client Name** (First, MI, Last)Click here to enter text. | **Date of Birth**Click here to enter text. |
| **Suspensions/Expulsions** [ ]  None reportedClick here to enter text. |
| **Other Academic School Concerns** (including performance/behavioral problems due to AOD use) [ ]  None reportedClick here to enter text. |
| **Barriers to Learning** [ ]  None reported [ ]  Inability to Read or Write [ ]  Other:Click here to enter text. |
| **Peer Relationships/Social Functioning**Click here to enter text. |
| **Special Communication Needs** [ ]  None reported [ ]  TDD/TTY Device [ ]  Sign Language Interpreter [ ]  Assistive Listening Device(s) [ ]  Language Interpreter Services Needed/Other Spoken Language: Click here to enter text. [ ]  Other: Click here to enter text. |
| **Employment** |
| [ ]  Not Pertinent – Skip this section |
| **Currently Employed?** [ ]  Yes [ ]  No If yes, name of employer |
| Name of Employer: Click here to enter text. Job Title: Click here to enter text. |
| **Employment Interests/Skills/Concerns**Click here to enter text. |

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| **Client Name** (First, MI, Last)Click here to enter text. | **Date of Birth**Click here to enter text. |
| **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 describeClick here to enter text. | [ ]  Status Offense (e.g., Unruly)[ ]  Delinquency |
| **Name of Probation/Parole Officer** (if applicable)Click here to enter text. |
| **Adjudications** [ ]  No [ ]  Yes If yes, describe: Click here to enter text. |
| **Detentions or Incarcerations** [ ]  No [ ]  Yes If yes, describe: Click here to enter text. |
| **Civil Proceedings** [ ]  No [ ]  Yes If yes, describe: Click here to enter text. |
| **Domestic Relations Court Involvement** [ ]  No [ ]  Yes If yes, describe: Click here to enter text. |
| **Juvenile Court Involvement (**related to child abuse, neglect, or dependency)Current: [ ]  No [ ]  Yes Comment: Click here to enter text.Past: [ ]  No [ ]  Yes Comment: Click here to enter text. | **Caseworker Name** (if applicable)Click here to enter text. |
| **Children’s Protective Services Involvement with Family** [ ]  No [ ]  Yes If yes, describe: Click here to enter text. |
| **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 |

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| **Client Name** (First, MI, Last)Click here to enter text. | **Staff Use Only: Client Number**Click here to enter text. | **Date of Birth**Click here to enter text. |
| **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 |[ ] [ ] [ ]  Click here to enter text. |
| Arthritis |[ ] [ ] [ ]  Click here to enter text. |
| Asthma |[ ] [ ] [ ]  Click here to enter text. |
| Bleeding Disorder |[ ] [ ] [ ]  Click here to enter text. |
| Blood Pressure (high or low) |[ ] [ ] [ ]  Click here to enter text. |
| Bone/Joint Problems |[ ] [ ] [ ]  Click here to enter text. |
| Cancer |[ ] [ ] [ ]  Click here to enter text. |
| Cirrhosis/Liver Disease |[ ] [ ] [ ]  Click here to enter text. |
| Diabetes |[ ] [ ] [ ]  Click here to enter text. |
| Epilepsy/Seizures |[ ] [ ] [ ]  Click here to enter text. |
| Eye Disease/Blindness |[ ] [ ] [ ]  Click here to enter text. |
| Fibromyalgia/Muscle Pain |[ ] [ ] [ ]  Click here to enter text. |
| Glaucoma |[ ] [ ] [ ]  Click here to enter text. |
| Headaches |[ ] [ ] [ ]  Click here to enter text. |
| Head Injury/Brain Tumor |[ ] [ ] [ ]  Click here to enter text. |
| Hearing Problems/Deafness |[ ] [ ] [ ]  Click here to enter text. |
| Heart Disease |[ ] [ ] [ ]  Click here to enter text. |
| Hepatitis/Jaundice |[ ] [ ] [ ]  Click here to enter text. |
| Kidney Disease |[ ] [ ] [ ]  Click here to enter text. |
| Lung Disease |[ ] [ ] [ ]  Click here to enter text. |
| Menstrual Pain |[ ] [ ] [ ]  Click here to enter text. |
| Oral Health/Dental |[ ] [ ] [ ]  Click here to enter text. |
| Stomach/Bowel Problems |[ ] [ ] [ ]  Click here to enter text. |
| Stroke |[ ] [ ] [ ]  Click here to enter text. |
| Thyroid |[ ] [ ] [ ]  Click here to enter text. |
| Tuberculosis |[ ] [ ] [ ]  Click here to enter text. |
| AIDS/HIV |[ ] [ ] [ ]  Click here to enter text. |
| Sexually Transmitted Disease |[ ] [ ] [ ]  Click here to enter text. |
| Learning Problems |[ ] [ ] [ ]  Click here to enter text. |
| Speech Problems |[ ] [ ] [ ]  Click here to enter text. |
| Anxiety |[ ] [ ] [ ]  Click here to enter text. |
| Bipolar Disorder |[ ] [ ] [ ]  Click here to enter text. |
| Depression |[ ] [ ] [ ]  Click here to enter text. |
| Eating Disorder |[ ] [ ] [ ]  Click here to enter text. |
| Hyperactivity/ADD |[ ] [ ] [ ]  Click here to enter text. |
| Schizophrenia |[ ] [ ] [ ]  Click here to enter text. |
| Sexual Problems |[ ] [ ] [ ]  Click here to enter text. |
| Sleep Disorder |[ ] [ ] [ ]  Click here to enter text. |
| Suicide Attempts/Thoughts |[ ] [ ] [ ]  Click here to enter text. |
| Other: Click here to enter text. |[ ] [ ] [ ]  Click here to enter text. |
| Other: Click here to enter text. |[ ] [ ] [ ]  Click here to enter text. |
| **Please note family history of any of the above conditions and client’s relationship to that family member**Click here to enter text. |

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| **Client Name** (First, MI, Last)Click here to enter text. | **Date of Birth**Click here to enter text. |
| **Current Medication Information** (medical and psychiatric prescription/OTC/herbal) |
|  [ ]  None Reported |
| **Medication** | **Rationale** | **Dosage/Route/Frequency** | **Staff Use Only: Compliance** |
|  |  |  | Yes | No | Partial | Unk |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |[ ] [ ] [ ] [ ]
| Click here to enter text. | Click here to enter text. | Click here to enter text. |[ ] [ ] [ ] [ ]
| Click here to enter text. | Click here to enter text. | Click here to enter text. |[ ] [ ] [ ] [ ]
| Click here to enter text. | Click here to enter text. | Click here to enter text. |[ ] [ ] [ ] [ ]
| Click here to enter text. | Click here to enter text. | Click here to enter text. |[ ] [ ] [ ] [ ]
| Click here to enter text. | Click here to enter text. | Click here to enter text. |[ ] [ ] [ ] [ ]
| **Primary Care Physician** (name, phone no., and address)Click here to enter text. | **Date of Last Physical Exam**Click here to enter a date. |
| **Other Prescribing Physician(s)** (name, phone no., and address)Click here to enter text. |
| **Past Psychiatric Medications** |
|  [ ]  None Reported |
| **Past Psychiatric Medications** | **Reason for Stopping** |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| **Has the child had medical hospitalization/surgical procedures in the last 3 years?** [ ]  No [ ]  Yes If yes, complete information below |
| **Hospital** | **City** | **Date** | **Reason** |
| Click here to enter text. | Click here to enter text. | Click here to enter a date. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter a date. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter a date. | Click here to enter a date. |
| Click here to enter text. | Click here to enter text. | Click here to enter a date. | Click here to enter text. |
| **Allergies/Drug Sensitivities** [ ]  None [ ]  Food (specify) Click here to enter text. [ ]  Medicine (specify) Click here to enter text. [ ]  Other (specify) Click here to enter text. |
| **Pregnancy History** [ ]  Not Pertinent |
| **Currently Pregnant?** (If yes, expected delivery date)[ ]  No [ ]  Yes Expected Delivery Date Click here to enter a date. | **Receiving Prenatal Healthcare?** (If yes, indicate provider)[ ]  No [ ]  Yes Provider Click here to enter text. |
| **Currently Breastfeeding?** [ ]  No [ ]  Yes |
| **Last Menstrual Period Date**Click here to enter a date. | **Any Significant Pregnancy History?** (if yes, explain)[ ]  No [ ] Yes Click here to enter text. |

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| **Client Name** (First, MI, Last)Click here to enter text. | **Date of Birth**Click here to enter text. |
| **Medical Information** |
| **Last Physical Examination**By Whom: Click here to enter text. Date:Click here to enter a date. Phone No.(if known): Click here to enter text. |
| **Indicate how many times in the past 12 months the child has used these medical services:**Click here to enter text. Hospital admissions Click here to enter text. Emergency room visitsClick here to enter text. Regular visits to doctor Click here to enter text. 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: Click here to enter text. |
| [ ]  Constipation | [ ]  Memory Problems | [ ]  Shakiness |  |
| [ ]  Coughing | [ ]  Mole/Wart Changes | [ ]  Sleep Problems | [ ]  Other: Click here to enter text. |
| [ ]  Cramps | [ ]  Muscle Weakness | [ ]  Sweats (night) |  |
| **Immunizations – Has the child had or been immunized for the following diseases?** (please check all that apply) |
| [ ]  Chicken Pox[ ]  Mumps | [ ]  Diphtheria[ ]  Polio | [ ]  German Measles[ ]  Small Pox | [ ]  Hepatitis B[ ]  Tetanus | [ ]  Measles[ ]  Other: Click here to enter text. |
| **Immunizations Within the Past Year**Click here to enter text. |
| **Height**Click here to enter text. | **Has client’s weight changed in the past year?**[ ]  No [ ]  Yes If yes, by how much (+ or -): Click here to enter text. |
|  |
| **Weight**Click here to enter text. |
| **Nutritional Screening** |
| **No Problem**[ ]  | **Eating**[ ]  More [ ]  Less [ ]  Not Eating | **Drinking**[ ]  More [ ]  Less [ ]  Takes Liquids Only | **Appetite**[ ]  Increased [ ] Decreased |
|   [ ]  Nausea [ ]  Vomiting [ ]  Trouble Chewing or Swallowing |
| **Special Diet**Click here to enter text. | **Other**Click here to enter text. |

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| **Client Name** (First, MI, Last)Click here to enter text. | **Date of Birth**Click here to enter text. |
| **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**Click here to enter text. |
| **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 | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  [ ]  Wine | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  [ ]  Liquor | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  [ ]  Heroin | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  [ ]  Barbiturates | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  [ ]  Amphetamines | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  [ ]  Crack | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  [ ]  Cocaine | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  [ ]  Marijuana/Hashish | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  [ ]  LSD | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  [ ]  Inhalants | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  [ ]  PCP | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  [ ]  MDMA (XTC) | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  [ ]  Prescription drugs off the street | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  [ ]  Non-prescription drugs by injection | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  [ ]  Other | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **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**Click here to enter text. | **Signature of Person Completing This Questionnaire** | **Date**Click here to enter text. |
| **Clinician Reviewer Comment** (if any) [ ]  Medical Review NeededClick here to enter text. |
| **Print Name of Clinician**Click here to enter text. | **Signature of Clinician**Click here to enter text. | **Date**Click here to enter text. |

|  |  |
| --- | --- |
| **Client Name** (First, MI, Last)Click here to enter text. | **Date of Birth**Click here to enter text. |
| **Comments, Recommendations or Referrals by Medical Reviewer**Check Referral(s) Needed and Specify Action(s) |
| [ ]  No Referral Needed[ ]  Primary Care Physician: Click here to enter text.[ ]  Healthcare Agency: Click here to enter text.[ ]  Specialty Care: Click here to enter text.[ ]  Other (specify): Click here to enter text. |
| **Recommendations shared with client?**[ ]  No [ ]  Yes If yes, client’s response: Click here to enter text. |
| **If no, how will recommendations be shared with client?** Click here to enter text. |
| **Medical Reviewer Signature/Credentials**  [ ]  Nurse [ ]  PA [ ]  NP [ ]  MD [ ]  DO | **Date**Click here to enter a date. |
| **Client Signature**Click here to enter text. | **Date**Click here to enter a date. |
| **Clinician Reviewing**Click here to enter text. | **Date**Click here to enter a date. |