



Mountain View Hospital

CENTER FOR WELLNESS & RECOVERY

*Please complete this form with the help of your child and bring to your first appointment.

This information is fundamental to the assessment and treatment process.

PATIENT CONTACT INFORMATION

Name _____ Age _____ Date of birth _____
 Parent/Guardian Name(s): _____
 Person completing form: _____ Relationship to child: _____
 Phone (____) _____ Mailing Address _____
 Emergency contact name _____ Relationship to emergency contact _____ Phone (____) _____

PRESENTING PROBLEMS AND CONCERNS

Describe the concern that brought you here today: _____

What has led you to seek help for this concern at this time? _____

Have you already tried to resolve this concern? If so, what did you do and how did it work? _____

How has this concern affected the family? _____

Please describe any stressors that may be affecting your child today (divorce, relationship changes, unemployment, school, peers, losses, etc.). Note changes in your child's mood or behavior as a result of these stressors: _____

Please check all your child's behaviors and symptoms that you consider problematic:

- | | | |
|--|---|--|
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Visual hallucinations |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Withdrawal from people | <input type="checkbox"/> Defiance |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Anxiety/Worry | <input type="checkbox"/> Aggression/Fights |
| <input type="checkbox"/> Boredom | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Homicidal thoughts |
| <input type="checkbox"/> Poor memory/Confusion | <input type="checkbox"/> Fear away from home | <input type="checkbox"/> Frequent arguments |
| <input type="checkbox"/> Sadness/Depression | <input type="checkbox"/> Social discomfort | <input type="checkbox"/> Irritability/Anger |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Phobias | <input type="checkbox"/> Peer/Sibling conflict |
| <input type="checkbox"/> Thoughts of death | <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Self-harm behaviors | <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> Destroys property |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Running away |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Wide mood swings | <input type="checkbox"/> Swearing |
| <input type="checkbox"/> Low self-worth | <input type="checkbox"/> Suspicion/Paranoia | <input type="checkbox"/> Curfew violations |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Recurring disturbing memories | <input type="checkbox"/> School failure | <input type="checkbox"/> Truancy |
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Substance use | <input type="checkbox"/> Sexual behavior |

What areas of functioning are being impacted by your child's behavior and symptoms?

- | | | | |
|--|--------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Handling everyday tasks | <input type="checkbox"/> Self-esteem | <input type="checkbox"/> Relationships | <input type="checkbox"/> Hygiene |
| <input type="checkbox"/> Work/School | <input type="checkbox"/> Housing | <input type="checkbox"/> Legal matters | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Recreational activities | <input type="checkbox"/> Health | <input type="checkbox"/> Other: | |

SAFETY CONCERNS

Has your child ever thought about hurting or killing him/herself, or had an impulse to do so? Yes No

If yes, does he/she have a suicide plan? Yes No

If so, please explain: _____

If your child has a plan, does he/she have the intention of acting on his/her plan? Yes No

If so, please explain: _____

What are your child's reasons for living? _____

Has your child ever tried to hurt or kill him/herself? Yes No

If yes, list the date(s), method(s) and how he/she was rescued: _____

Has your child ever harmed property, other people or thought seriously about causing harm to someone? Yes No

If yes, please explain: _____

Is your child having thoughts of harming someone right now? Yes No

If yes, please explain: _____

Are there firearms in your home? Yes No

How many and of what type (pistol, revolver, rifle, automatic)? _____

Do the children in your home have access to these firearms? Yes No

Are these firearms stored unloaded and locked with trigger guards? Yes No (Trigger guards are free of charge from local police departments)

Is the ammunition (bullets) kept in a separate location? Yes No

Has your child recently been physically hurt or threatened by someone else? Yes No

If yes, please describe: _____

Has your child talked to you about the safety concerns above? Yes No

If yes, who: _____

When did your child tell you and what was your response? _____

Who have you told and what has been their response? _____

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Age	Quality of Relationship	Family Mental Health History	Who?
Mother				Major Depressive Disorder	
Father				Bipolar Disorder	
Stepmother				Posttraumatic Stress Disorder	
Stepfather				Obsessive Compulsive Disorder	
Siblings				Schizophrenia	
				Eating Disorder	
				Alcohol Abuse	
				Drug Abuse	
Other relatives				Personality Disorder	
				Suicidal Action/Completion	
				Victim of Abuse	
				Abusive/Domestic Violence	
				Other:	

Please describe your child's living situation. Check all that apply:

- With biological parents With another relative: With foster parents
 With adoptive parents In an institution/group home Other:

Please check most appropriate description of parental marital status:

- Parents legally married or living together Mother remarried Number of times _____
 Parents temporarily separated Father remarried Number of times _____
 Parents divorced or permanently separated

Please check if your child has experienced any of the following types of trauma or loss:

- Emotional abuse Neglect Lived in a foster home
 Sexual abuse Violence in the home Multiple family moves
 Physical abuse Crime victim Homelessness
 Parent alcohol or substance abuse Parent serious illness Loss of a loved one
 Teen pregnancy Placed a child for adoption Financial problems
 Abortion Other: Other:

Were there any medical problems during the pregnancy or birth of your child? Yes No If yes, please describe: _____

Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant with this child? Yes No
 If yes, please describe substances used, quantity, and frequency: _____

Did your child have any developmental delays in early childhood (crawling, walking, talking, toileting, etc.)? Yes No
 If yes, please describe: _____

ACADEMIC INFORMATION

Current grade/placement: _____

This year's school grades:

Past school grades:

This year's school behavior:

Past school behavior:

- | | | | |
|------------------------------------|-------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |

Has your child had any of the following difficulties at school?

- | | | |
|---|--|--|
| <input type="checkbox"/> Suspension/Expulsion | <input type="checkbox"/> Incomplete homework | <input type="checkbox"/> Learning difficulties |
| <input type="checkbox"/> Referrals/Detention | <input type="checkbox"/> Poor grades | <input type="checkbox"/> Teased or Bullied |
| <input type="checkbox"/> Speech | <input type="checkbox"/> Truancy | <input type="checkbox"/> Gang involvement |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Seeing | <input type="checkbox"/> Attention |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Writing | <input type="checkbox"/> Math |
| <input type="checkbox"/> Held back | <input type="checkbox"/> IEP/Special Education | <input type="checkbox"/> Other: |

Does your child have an after-school provider? Yes No If so, who?

Has your child ever repeated or skipped a grade? Yes No If yes, which one(s)? _____

Has your child ever received Special Education services? Yes No If yes, please describe services received and reason for services:

What does your child's teacher(s) say about him/her? _____

PREVIOUS MENTAL HEALTH TREATMENT

		Type of Treatment	When?	Provider/Program	Reason for Treatment
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Outpatient psychotherapy			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric medication			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric hospitalization			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Addiction treatment			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Self-help/Support groups			

SUBSTANCE USE HISTORY

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
PCP/LSD								
Spice								
Bath Salts								
Prescription Pain Medications								
Prescription Anxiety Medications								

Yes No Has your child had withdrawal symptoms when trying to stop using any alcohol or any other substances? If yes, please describe:

Yes No Has your child ever had problems with work, relationships, health, the law, etc. due to his/her alcohol or substance use? If yes, please describe:

MEDICAL INFORMATION

Does your child have a primary care clinic or medical provider? Yes No

Name of clinic or provider _____

Phone (_____) _____ Fax (_____) _____

Has your child had a physical exam to check for medical reasons for his/her symptoms? Yes No

Date of his/her last physical exam _____

In the past year, has your child had screening or testing for the following?

Vision. If so, does your child have or need glasses or contact lenses? Yes No

Hearing. If so, does your child have or need a hearing aid? Yes No

If a doctor has prescribed visual or hearing aids, does the child wear them? Yes No N/A

Has your child experienced any of the following medical conditions during his/her lifetime?

- Allergies Asthma Headaches Stomach aches
- Chronic pain Surgery Serious accident Head injury
- Dizziness/fainting Meningitis Seizures Vision problems
- High fevers Diabetes Hearing problems Miscarriage
- Sexually transmitted disease Abortion Sleep disorder Other:

Please list any CURRENT medical concerns: _____

Does your child have a psychiatric provider? Yes No

Name of provider _____

Phone (_____) _____ Fax (_____) _____ Date of last visit: _____

If so, why are you seeking services at our center? _____

Current prescription medications: None

	<u>EXAMPLE</u>	Medicine #1	Medicine #2	Medicine #3	Medicine #4	Medicine #5	Medicine #6
Name of medicine	Celexa						
How many milligrams (mg)?	40 mg						

How many pills do you take at a time?	one						
How many times a day do you take this medicine?	once						
What time of day do you take this medicine?	morning						
What does this medicine treat?	depression						
Name of prescriber	Dr. John Smith						

If you need more space, please attach another sheet of paper.

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____

Allergies and/or adverse reactions to medications: None
 If yes, please list: _____

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your child's social support network (check all that apply):

- Family Neighbors Friends Students/Co-workers
- Support/Self-Help Group: _____ Community Group: _____
- Religious/Spiritual Group: _____ Cultural/Ethnic Group: _____

If your child is experiencing any difficulties due to interpersonal, social or cultural issues, please describe: _____

Do you have concerns about your child's friends? Yes No If yes, please explain: _____

Does your child have a best friend? Yes No If no, please explain: _____

Is your son/daughter dating? Yes No If this is a concern, please explain: _____

How important are interpersonal, social, or cultural issues matters to your child?

- Not at all Very little Somewhat Very Much

Would you like these perspectives and concerns to be incorporated into your services? Yes No

Please describe your child's strengths, skills and talents? _____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.): _____

LEGAL INFORMATION

Have you ever been convicted of a misdemeanor or felony? Yes No If yes, please explain: _____

Are you currently involved in any divorce or child custody proceedings? Yes No If yes, please explain the current child custody/visitation arrangement and/or status of the proceedings: _____

Has your child ever been a ward of the court with DWH or IDJC guardianship? Yes No If yes, please explain: _____

