



**Has the Child/Adolescent received any previous counseling/psychiatric or substance abuse treatment?**

TX PROVIDER/ FACILITY NAME	DATE	REASON FOR TREATMENT	LEVEL (check one)			
			Inpatient,	Partial,	Residential,	Out Pt
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MEDICAL HISTORY:** (Please check any of the following medical problems your child has experienced)

- |  |   |  |                                       |   |
|--|---|--|---------------------------------------|---|
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Bowels                 | <input type="checkbox"/> Respiratory       | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Herpes             |
| <input type="checkbox"/> Cardiac         | <input type="checkbox"/> Emphysema              | <input type="checkbox"/> Ulcers            | <input type="checkbox"/> Chlamydia    | <input type="checkbox"/> Meningitis         |
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Hypertension           | <input type="checkbox"/> Cancer            | <input type="checkbox"/> Gonorrhea    | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Cirrhosis       | <input type="checkbox"/> Liver                  | <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> Syphilis     | <input type="checkbox"/> Toxoplasmosis      |
| <input type="checkbox"/> Thyroid         | <input type="checkbox"/> Kidney                 | <input type="checkbox"/> Gynecological     | <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever          | <input type="checkbox"/> Neurological exam |                                       |   |
| <input type="checkbox"/> Hemophilia      | <input type="checkbox"/> Seizures, type: _____  |  |                                       |   |
| <input type="checkbox"/> Chicken Pox     | <input type="checkbox"/> Hepatitis, type: _____ |  |                                       |   |
| <input type="checkbox"/> Other : _____   |   |  |                                       |   |

**MEDICATIONS:** (All Current Medications Client is taking)

Current Medications	Dosage/Frequency	Prescribed by	Last use	Is medication being taken as prescribed?
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO

List all allergies (include medications, foods, insects, substances, & any others):

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Please list all health care providers treating you at this time: \_\_\_\_\_

**Physical Pain Screening:**

Please circle the face that corresponds to your level of physical pain today.



If you have physical pain today, describe what is causing your pain:

Have you talked with your medical doctor about your pain?

**LEGAL STATUS ASSESSMENT:**

Please provide an explanation of any legal involvement:

Are there any current/pending legal problems?  YES  NO

Are you on probation/parole?  YES  NO (If yes, P.O.'s name & phone)

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Do you have previous legal history?

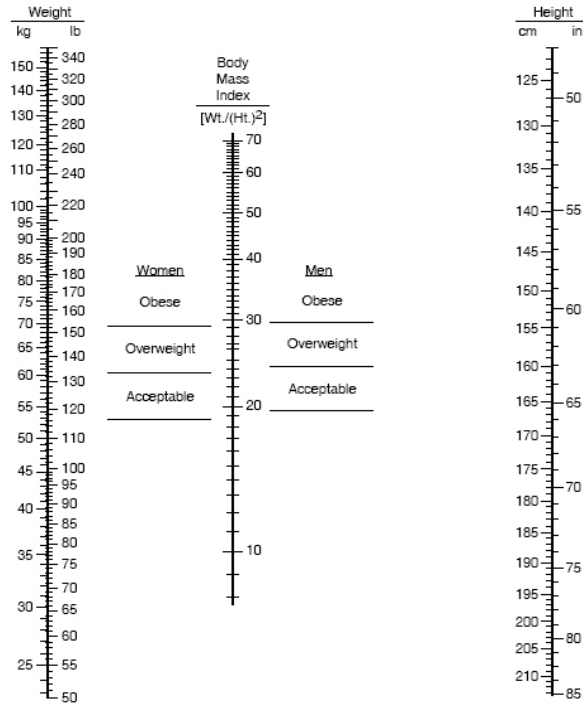
YES  NO

Will legal situation impact treatment?

YES  NO

**Nutrition Screening:**

Please mark your height in inches and your weight in lbs.



Please Circle each number if you answer yes to any of the questions below:	Yes
I have lost or gained 10 lbs. in past 6 months	2
I do not have enough food to eat each day	1
I do not eat 1 or more days each month	2
I have an illness that has made me change the kind and/or amount of food I eat	1
I eat fewer than 2 meals per day	1
I eat few fruits or vegetables or milk products	1
I have 3 or more drinks of beer, liquor or wine each day	2
I have tooth or mouth problems that makes it hard to eat	1
I don't always have enough money to buy the food I need	1
I eat alone most of the time	1
I have a history of bingeing and/or purging	2
I exercise excessively to maintain weight	2
I am anorexic	2
<b>0 – 2 Good!</b> <b>3 – 7 You are at moderate nutritional risk:</b> See what can be done to improve your eating habits and lifestyle. <b>8 or more You are at high nutritional risk:</b> You may need to be under the help of a qualified medical doctor or counselor.	

**ALCOHOL/DRUG HISTORY:**

Any History of drug/alcohol use?  YES  NO If NO, go to Psychosocial History.

- |                                   |   |  |  |
|-----------------------------------|---|--|--|
| <input type="checkbox"/> Alcohol  | <input type="checkbox"/> Marijuana                | <input type="checkbox"/> Stimulants    | <input type="checkbox"/> Barbiturates                            |
| <input type="checkbox"/> Cocaine  | <input type="checkbox"/> Hallucinogens (Acid/LSD) | <input type="checkbox"/> Methadone     | <input type="checkbox"/> Pain Medications                        |
| <input type="checkbox"/> Crack    | <input type="checkbox"/> Opiates                  | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Over-the-counter Medications            |
| <input type="checkbox"/> Tobacco  | <input type="checkbox"/> Heroin                   | <input type="checkbox"/> Sedatives     | <input type="checkbox"/> Crank                                   |
| <input type="checkbox"/> Caffeine | <input type="checkbox"/> Inhalants                |  | <input type="checkbox"/> Methamphetamine (Ecstasy, crystal meth) |

Other: \_\_\_\_\_

**COMPLETE THE FOLLOWING FOR THE ITEMS CHECKED ABOVE:**

Substance Checked	Amt/Frequency	Duration of Use	First Use	Last Use	Amt. used in last 24 hours

Withdrawal Symptoms/behaviors from alcohol/drug use: (Check all that apply)

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Aggression/assaultive | <input type="checkbox"/> Cramps                   | <input type="checkbox"/> Agitation       | <input type="checkbox"/> Weakness         |
| <input type="checkbox"/> Profuse sweating      | <input type="checkbox"/> Change in blood pressure | <input type="checkbox"/> Tingling        | <input type="checkbox"/> Rapid heart beat |
| <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Fever/chills             | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Tremors          |
| <input type="checkbox"/> Irritability          | <input type="checkbox"/> Delirium                 | <input type="checkbox"/> Anorexia        | <input type="checkbox"/> None             |

*Please complete all pages!*

**PSYCHOSOCIAL HISTORY:**

Describe the client's leisure and recreational activities:

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 What type of social activities does the client participate in?
 

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Has the client ever been a victim of physical/sexual abuse?  YES  NOHas the client ever been sexually active?  YES  NOHas the client ever physically or sexually abused another person?  YES  NO**SUPPORT SYSTEMS**

(availability of family/friends to participate in treatment, special family concerns)

**LIST OF PEOPLE LIVING IN CHILD'S HOME, NOT INCLUDING CLIENT:**

NAME	RELATION TO CLIENT	AGE	GENDER	OCCUPATION

Do you want your significant other or anyone in your family to participate in your treatment?  
If so, who?

**REVIEW OF COMMUNITY RESOURCES**

(check all that apply now or that you have used in the past):

- Church       Health Dept       Medical Clinics       Voc. Rehab       Adult Ed.  
 Housing       Schools       SSI/Medicaid       SSA/Medicare       Food Stamps/WIC  
 Child       Insurance       Family/Friends       Financial Aid  
 DFCS: Name of current case worker  
 Other community resources (please specify):

**EDUCATIONAL ASSESSMENT:**

Current school:		Current grade:	
Usual Grades:		Changes in grades lately?	<input type="checkbox"/> YES <input type="checkbox"/> NO
History of being retained?		History of Spec. Ed?	
Any other educational needs:			

**Safety Risk Screening:**

Please Circle the number to the left if any of the following are true:	
	<b>Risk Factors</b>
1	Current/past psychiatric diagnosis: I have been diagnosed with a mood disorder, psychotic disorder, alcohol/substance abuse addiction.
1	Key Symptoms: I experience any of the following symptoms: depression, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
2	Suicidal Behavior: I have a history of past attempts of suicide or self-injurious behaviors
1	Family: I have a family history of suicide or suicide attempts and/or a family history of mental health problems
1	Precipitating Factors: I have experienced public humiliation, shame or despair (i.e. loss of relationship, financial problems, health status changed) or I have been diagnosed with an ongoing medical illness
1	I have access to firearms
	<b>Protective Factors</b>
-1	I have the ability to cope with stress and I have religious beliefs against self-harm
-1	I have a responsibility to my children or loved ones and I have positive outlets for expressing myself

*Please complete all pages!*

	and being understood
	<b>Suicide Inquiry</b>
2	I have a been thinking about suicide during the past <input type="checkbox"/> 48 hours <input type="checkbox"/> month <input type="checkbox"/> Year
2	I know when, how and where I would commit suicide
2	I have attempted suicide in the past and I have rehearsed (literally or in my mind) how I would commit suicide or hurt myself
2	I have a desire to physically hurt someone else

Risk Level Score: \_\_\_\_\_

Please check any of the symptoms listed below which apply to your child:

	Current	History	N/A
Depressed mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of worthlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manic thought/behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crying spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive/compulsive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes in Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change in Energy Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disorganized/Disoriented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Binging/Purging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Acting Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Promiscuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distractibility/Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying/Manipulative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running Away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Truancy/Absenteeism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Property Destruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cruelty to Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stealing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other legal Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oppositional Behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Religious/Spiritual Concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talk of Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What do you hope is changed as a result of coming to counseling?

Is there anything else you would like your counselor to know?

*Please complete all pages!*