

**Children/Adolescents
(Age 17 and under)**

SAINT JOSEPH MERCY
OUTPATIENT BEHAVIORAL SERVICES

Confidential Information Form for Children/Adolescents
(To be completed by Parent or Guardian)

- Please answer each question.
- **DO NOT LEAVE ANY BLANK AREAS.**
- Write NA or put a line through (IF THE QUESTION DOES NOT APPLY).
- Discuss question(s) with the therapist if you are unsure/uncomfortable with what is being asked.

Child's Name: _____ Date: _____

Date of Birth: ____/____/____ Child's Age: _____ Medication Allergies? _____ Height _____ Weight _____

EMERGENCY CONTACT _____ **RELATIONSHIP** _____ **PHONE #** _____

School and Grade: _____ Has child ever been home-schooled? Yes No

Teacher and / or counselor: _____

1. Reason for bringing child to Saint Joseph Mercy Behavioral Services? _____

2. What caused you to bring the child in now? _____

3. Who referred you to us? _____

4. How do you want your child's situation to be different after coming here? _____

5. What have your child, you or others already done or tried to do to address this problem(s)? _____

FOR CLINICIAN USE ONLY

Presenting problem / history of problem:

PREGNANCY AND DELIVERY/DEVELOPMENTAL INFORMATION:

1. Was this a planned pregnancy? Yes No Age of mother at birth? _____
2. Was pregnancy normal? Yes No If not, please describe. _____
3. If mother was ill during pregnancy, state illness, month of pregnancy, type of treatment received, and how long condition lasted:

4. Was infant premature? Yes No If premature, how early? _____ Birth weight of child: _____lbs. _____oz
5. How well do you think your child bonded with you? _____
6. Indicate condition of child in first six weeks of life. Answer "Y" (Yes), "N" (No), or "U" (Unknown)
- | | | |
|----------------------------|------------------|----------------------------------|
| _____ Yellow appearance | _____ Blue lips | _____ Vomiting |
| _____ Difficulty Breathing | _____ Irritable | _____ Nursing/Feeding difficulty |
| _____ Deformed | _____ High fever | _____ Convulsions or twitching |
| _____ Slow in responding | Other? _____ | |
7. Were there ever any problems from age 1-4, Toddler years with head banging, rocking, thumb sucking, teeth grinding, temper tantrums, or hyperactivity? Yes No If yes, describe: _____

FOR CLINICIAN USE ONLY

DEVELOPMENTAL HISTORY	Within Normal Limits		If No, Explain
	Yes	No	
Motor Development and Functioning			
Sensorimotor Functioning			
Speech, hearing, and language functioning			
Visual functioning			

FAMILY INFORMATION:

1. Place of birth: _____
2. Child's ethnicity? _____
3. Was the child adopted? Yes No If yes, at what age? _____

4. Parents / Step Parents:

Father's Name _____**Mother's Name** _____

Address _____

Address _____

Occupation & Age _____

Occupation & Age _____

Phone: (h) _____ (w) _____ (c) _____

Phone: (h) _____ (w) _____ (c) _____

Stepfather _____**Stepmother** _____

Address _____

Address _____

Occupation & Age _____

Occupation & Age _____

Phone: (h) _____ (w) _____ (c) _____

Phone: (h) _____ (w) _____ (c) _____

5. Who has physical custody of the child? _____

6. Who has legal custody of the child? _____

7. Who resides in the household?

(Name)

(Age)

(Relationship)

(Name)	(Age)	(Relationship)

8. Siblings not in same home?

(Name)

(Age)

(Relationship)

(Name)	(Age)	(Relationship)

9. Has the child ever been placed outside of the home? Yes No

If yes, where? _____

10. How many residences has the child lived in since birth? _____

11. Who would you like involved in the child's treatment? _____

FOR CLINICIAN USE ONLY**Family history:**

FAMILY INFORMATION (continued):

12. Have any of the following stress events occurred? Check any appropriate ones:
- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Family accident or illness | <input type="checkbox"/> Death in family | <input type="checkbox"/> Death/loss of family pet | <input type="checkbox"/> Parents divorced or separated |
| <input type="checkbox"/> Birth of brother/sister | <input type="checkbox"/> Changed schools | <input type="checkbox"/> Family moved | <input type="checkbox"/> Parent changed job |
| <input type="checkbox"/> Friend moving away | <input type="checkbox"/> Marital Conflict | <input type="checkbox"/> None | <input type="checkbox"/> Family financial problems |
| <input type="checkbox"/> Other? (please specify) _____ | | | |

13. Has the child ever been physically or sexually abused, assaulted or molested? Yes No Don't know
If yes, please specify by whom and when: _____

14. Have child's parents or any other family members had any mental health or emotional problems? Yes No
If yes, describe: _____

15. Have child's parents or any other family members had any problems with alcohol or drugs? Yes No
If yes, describe: _____

16. Describe child's relationship with his / her:
- Father _____
- Mother _____
- Siblings _____
- Stepfather _____
- Stepmother _____

OTHER INTERPERSONAL RELATIONSHIPS:

1. How would you describe child's friendships:
 No Friends Only acquaintances Both acquaintances and close friends How many close friends? _____
2. Does your child have any history of teasing or bullying or shunning others? Yes No
Or Has your child ever been the victim of such? Yes No
If yes to either, please describe: _____

FOR CLINICIAN USE ONLY**Family psychiatric / substance abuse history:****Present family situation:****Family's expectations of child:****Social relationships:**

SCHOOL HISTORY

1. School _____ Grade _____ Teacher _____
Is your child currently in a special program? Yes No If yes, explain: _____
2. Has the child had any vocational training? Yes No If yes, explain: _____
3. Has the child ever: Been in special classes other than above? Yes No
Been tutored? Yes No If yes, what subjects? _____
Had speech and language or occupational training? Yes No
Had an I.E.P. or 504 Plan? Yes No
4. If child is of school age, but not presently in school, since when? _____
For what reason? _____
5. Has child attended school regularly? _____ If not explain? _____
6. Has the child's average grade changed in the past 6 months? Yes No What is the current average grade? _____
7. Does child enjoy school? Yes No Somewhat Describe _____
8. Has the child ever: Been suspended? Yes No When? _____
Been expelled? Yes No When? _____

LEISURE ACTIVITIES AND PLAY

1. How does your child spend non-school time? _____
2. How much of his / her non-school time does your child spend playing with you? _____
Family members? _____
Friends, others? _____
3. List some of your child's hobbies, activities, community involvement, and talents: _____

FOR CLINICIAN USE ONLY**Mental functioning:****School history and current school performance:****Leisure time / daily activities pattern:**

CURRENT HEALTH INFORMATION:

1. Describe child's health generally: Good Fair Poor
2. Physician: _____
Address: _____ Phone # _____
3. Date of last physician contact: ____ / ____ / ____ Reason for last contact: _____
4. List any health problems the child has had: _____

5. Are child's immunizations current? Yes No If no, what immunizations are needed: _____
6. Allergies: _____
7. List all medications child is currently taking (include all over-the-counter and alternative/herbal remedies being taken and how often).

Name of Medication	Prescribing Doctor's Name (or over-the-counter)	Dosage & Frequency	For What Condition

8. Has the child ever been exposed to high levels of lead? Yes No Unsure Describe: _____
9. Is child sexually active? Yes No Unsure
10. Has the child had any serious contagious and / or other diseases? Yes No If yes, explain: _____
11. Does the child have a Disability / Handicap? Yes No If yes, explain: _____
12. Has the child ever had surgery? Yes No If yes, explain: _____

13. Accidents / injuries? Yes No If yes, explain: _____

14. Year / reason for any hospitalizations: _____ / _____

PHYSICAL PAIN

- Is the child currently experiencing any physical pain? Yes No
- Where are the locations of the child's pain? _____
- How would you describe the child's pain? _____
- Rate on a scale of 1-10 ("1" being the least and "10" being the greatest) the level of intensity of the child's current pain _____ (1-10)
- Is the child currently being treated for pain? Yes No
- If yes, list the name of the treating professional and facility: _____

- If the child is being treated, is the treatment effective in reducing the level of pain? Yes No
- What strategies have you and the child found to be helpful in managing the pain? Please describe: _____

FOR CLINICIAN USE ONLY**Physical health / nutrition:**

HEALTH CHECKLIST (Check any that apply)

PRESENT HEALTH	Currently Having Symptoms	Being treated? Y/N (Name physician If being treated)
1. Frequent headaches.....	1.	
2. Trouble sleeping.....	2.	
3. Double vision	3.	
4. Blurred vision	4.	
5. Hearing difficulties.....	5.	
6. Deafness or hearing loss.....	6.	
7. Dental problems.....	7.	
8. Sore tongue.....	8.	
9. Many chest colds.....	9.	
10. Unusual weight gain or loss	10.	*
11. Sore throats.....	11.	
12. Frequent coughing.....	12.	
13. Coughing up blood.....	13.	
14. Wheezing, gasping.....	14.	
15. Chest pains.....	15.	
16. Shortness of breath.....	16.	
17. Dizzy spells.....	17.	
18. Swollen feet or ankles.....	18.	
19. Excessive tiredness or weakness.....	19.	
20. Vomiting (throwing-up) blood.....	20.	*
21. Rectal bleeding.....	21.	
22. Stomach pain.....	22.	
23. Loss of appetite.....	23.	*
24. Frequent urination.....	24.	
25. Night urination.....	25.	
26. Excessive appetite.....	26.	*
27. Difficulty starting urination.....	27.	
28. Bloody or coffee colored urine.....	28.	
29. Faintness.....	29.	
30. Numbness.....	30.	
31. Fits or convulsions.....	31.	
32. Tendency to shake or tremble.....	32.	
33. Any ulcers/open wound.....	33.	*
34. Other.....	34.	

HEALTH QUESTIONS FOR FEMALES ONLY:

Date of child's last pap smear _____

Does your child take birth control measures? _____

Describe any menstrual trouble the child may be having: _____

*** May indicate nutrition risk**_____
Parent/Guardian Signature_____
Birth date_____
Today's date

SUBSTANCE USE / ABUSE

Category of Drug	Has child used ever?	Currently using	Age at first use	How often used?	How taken?	How much?	Use last 48 hours?	Withdrawal symptoms
Alcohol								
Stimulant								
Cocaine								
Tranquilizer								
Barbiturate								
Marijuana								
Opiod								
Hallucinogen								
Inhalant								
Prescribed								
Nicotine								
Caffeine								
Other								

RELIGION / SPIRITUALITY

1. Religion: Protestant Catholic Hindu Jewish Muslim Atheist Agnostic
 Other: _____
2. Is child presently active in his/ her religion? Yes No
3. Would you like your therapist to incorporate your religious views into treatment? Yes No Describe _____

LEGAL INFORMATION

1. Has child ever: Had difficulty or contact with police? Yes No
 Appeared in juvenile conference? Yes No
 Been on Probation? Yes No

If yes to any of the above, describe circumstances and give dates:

FOR CLINICIAN USE ONLY

Substance Abuse:

Legal status:

CURRENT SYMPTOM CHECKLIST

Check "yes" for any of the following behaviors which have been or currently are a significant problem.

Check "no" if this behavior has not been a significant problem.

1.

	YES	NO
Often makes careless mistakes.		
Often has difficulty maintaining attention.		
Often does not seem to listen.		
Often has difficulty following directions.		
Often has difficulty organizing tasks.		
Often avoids or dislikes schoolwork.		
Often loses things.		
Often is easily distracted.		
Often is forgetful.		
TOTAL		

At what age did these problems begin? _____

2.

	YES	NO
Often fidgets.		
Often leaves seat.		
Often runs about or climbs excessively.		
Often has difficulty playing quietly.		
Often is "on the go".		
Often talks excessively.		
Often blurts out answers.		
Often has difficulty awaiting turn.		
Often interrupts or intrudes on others.		
TOTAL		

At what age did these problems begin? _____

3.

	YES	NO
Often loses temper.		
Often argues with adults.		
Often defies rules.		
Often deliberately annoys others.		
Often blames others for own mistakes.		
Often is touchy or easily annoyed.		
Often is angry or resentful.		
Often is spiteful or vindictive.		
TOTAL		

At what age did these problems begin? _____

CURRENT SYMPTOM CHECKLIST (continued)

Check "yes" for the following behaviors which have been or currently are a significant problem.

Check "no" if this behavior has not been a significant problem.

4.

	YES	NO
Often bullies or threatens others.		
Often starts fights.		
Has used a weapon in a fight.		
Has been physically cruel to people.		
Has been physically cruel to animals.		
Has stolen while confronting a victim.		
Has set fires to harm others		
Has deliberately destroyed others property.		
Has broken into a house or car.		
Often lies.		
Has stolen without confronting a victim.		
Often stays out past parents set curfew.		
Has run away from home two or more times.		
Often is truant from school		
TOTAL		

At what age did these problems begin? _____

5.

	YES	NO
Depressed or irritable mood most of the day, nearly everyday.		
Diminished pleasure in activities.		
Decrease or increase in appetite.		
Trouble sleeping or oversleeping nearly everyday.		
Psychomotor agitation or retardation.		
Fatigue or loss of energy most days.		
Feelings of worthlessness or excessive guilt.		
Diminished ability to concentrate.		
Suicidal thoughts or attempt.		
TOTAL		

At what age did these problems begin? _____

6.

	YES	NO
Depressed or irritable mood for most of the day for one year or more.		
Poor appetite or overeating.		
Under or over sleeping.		
Low energy or fatigue.		
Low self esteem.		
Poor concentration or difficulty making decisions.		
Feelings of hopelessness.		
Never without above behaviors for more than two months at a time.		
TOTAL		

At what age did these problems begin? _____

CURRENT SYMPTOM CHECKLIST (continued)

Check "yes" for the following behaviors which have been or currently are a significant problem.

Check "no" if this behavior has not been a significant problem.

7.

	YES	NO
Excessive distress when separated from home or significant adults.		
Unrealistic worry about losing or possible harm occurring to a significant adult.		
Unrealistic worry that they will be separated from a significant adult.		
Persistent reluctance or refusal to attend school.		
Persistent avoidance of being alone.		
Persistent refusal to sleep alone.		
Persistent nightmares re: separation.		
Repeated physical complaints when separation occurs or is expected.		
TOTAL		

At what age did these problems begin? _____

8.

	YES	NO
Excessive, difficult to control anxiety and worry.		
Keyed up or on the edge.		
Easily fatigued.		
Difficulty concentrating.		
Irritable.		
Muscle tension.		
Sleep difficulty.		
TOTAL		

At what age did these problems begin? _____

9.

	YES	NO
Stereotyped mannerisms.		
Odd postures or unusual movements.		
Excessive reaction to noise.		
No reaction to loud noises.		
Overreacts to touch.		
Compulsive rituals like handwashing.		
Motor tics like a physical twitch.		
Bizarre ideas, hearing or seeing things which aren't there.		
Disoriented, confused, staring or spacey.		
Incoherent speech (mumbles).		
Little or no interest in peers.		
Significant indiscreet remarks.		
Starts or stops interactions inappropriately.		
Abnormal speech.		
Self-abusive (hitting, biting, cutting).		
Vocal tics or unusual sounds.		
Explosive temper without provocation.		
Unusual fears.		
Panic attacks.		
TOTAL		

At what age did these problems begin? _____

PREVIOUS TREATMENT

1. Has the child been seen previously for treatment or evaluation of emotional or behavioral problems? Check if applicable:

- Inpatient
 Outpatient
 Day treatment
 Psychological testing
 Substance abuse program
 Psychiatric evaluation

Name of Center / Individual **Address** **Year** **Was treatment helpful?** Yes No

2. Is child currently expressing homicidal / suicidal thoughts or feelings? Yes No If yes, explain _____

3. Has child ever made a suicide attempt in the past? Yes No If yes, in what year(s): _____
 Explain: _____

4. Has child ever expressed homicidal thoughts or feelings? Yes No If yes, explain: _____

5. Has child ever experienced explosive anger? Yes No If yes, explain: _____

Signature of person completing form: _____ **Date:** _____

Relationship to child: _____

THIS SECTION FOR CLINICIAN USE ONLY

PREVIOUS PSYCHIATRIC TREATMENT:

SUICIDALITY / HOMICIDALITY:

- Client denies any **current** suicidal or homicidal thoughts, feelings, gestures, intentions or plans.
 Client reports **current** suicidal or homicidal feelings. Specify: _____

 Client denies history of suicidal or homicidal thoughts, feelings, gestures, intentions or plans.
 Client has history of suicidal or homicidal thoughts, feelings, gestures, intentions or plans. Specify: _____
