

Name: _____

PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (mental health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/Support Groups			

Therapist Notes:
Init: _____

SCHOOL INFORMATION

Current grade/placement: _____

- | | | | | |
|------------------------------|------------------------------------|-------------------------------|-------------------------------|-------------------------------|
| This year's school grades: | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Past school grades: | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| This year's school behavior: | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Past school behavior: | <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 | <input type="checkbox"/> Incomplete homework | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Referrals or detentions |
| <input type="checkbox"/> Poor grades | <input type="checkbox"/> Teased or picked on | <input type="checkbox"/> Speech problems | <input type="checkbox"/> Attendance problems |
| <input type="checkbox"/> Gang influence | | | |

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

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

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

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

Therapist Notes:
Init: _____

Name: _____

SUBSTANCE USE HISTORY (for ages 12 and older or if applicable)

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								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

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

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

Therapist Notes:
Init: _____

MEDICAL INFORMATION

Date of last physical exam: _____

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

- | | | | |
|---------------------------------------------|-------------------------------------|-------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Surgery | <input type="checkbox"/> Serious accident | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> High fevers | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Abortion | <input type="checkbox"/> Sleep disorder | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Other: _____ | | | |

Please list any CURRENT health concerns: _____

Current prescription medications: None

Medication	Dosage	Date First Prescribed	Prescribed By

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

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

Therapist Notes:
Init: _____

