Confidential Health Assessment Form-CHILD/TEEN

(To be filled out by the parent/guardian)

Client Name:________________________________ DOB______________ Date:____________________

Name of person completing this form:____
Relationship to Client

Developmental Screening

Were there any problems with the pregnancy? ☐No
If yes, please list:____
Were any substances or medications used during pregnancy? ☐No
If yes, please list:____
Were there any problems during labor, birth, or following birth? ☐No
If yes, please list:____
Were there any problems with feeding, sleeping, or toileting during infancy or early childhood? ☐No
If yes, please list:____
Were there any problems with developmental milestones (e.g. walking, speaking, toileting)? ☐No
If yes, please list:____
Describe temperament: ☐Average ☐Difficult ☐Very Difficult
Describe activity level: ☐Very Active ☐Active ☐Average ☐Less Active
Are there any current problems with health, hearing, vision, or motor coordination? ☐No
If yes, please list:____
Is there any history of physical/sexual abuse, suspected or substantiated? ☐No
If yes, is Children's Protective Services involved? ☐Yes ☐No
If yes, is the case in litigation? ☐Yes ☐No
Is there any suicidal history or suspicion of self harm? ☐No
If yes, please describe:____

Please describe any serious health problems, injuries or surgeries for your child, past or present.____
____
__

____***Please check all of the items that apply to your child/teen:***

_____ Anemia _____ Fainting _____ Pneumonia
_____ Rashes _____ Fever (unknown origin) _____ Eating
Problem_________________________
_____ Asthma _____ Headaches _____ Sexual difficulty
_____ Bleeding Disorder _____ Hearing Impairment _____ Sexually Transmitted Disease
_____ Cancer _____ Heart Problem _____ Thyroid Problem
_____ Diarrhea _____ High Blood Pressure _____ Tuberculosis
_____ Diabetes _____ HIV illness _____ Ulcer
_____ Dizziness _____ Liver problem _____ Low Blood Pressure
_____ Seizures _____ Weight Gain or Loss _____ Eye Problem
_____ Nausea _____ Fatigue _____ Depression or Anxiety
_____ Bowel Problem _____ Pain _____ Sleeping Problem
_____ Enuresis (urination)
_____ Other____
_____ Allergies (food, animals, medicines or other substances):_________________________
____
____

Please identify the doctor or clinic treating for the above items:

Problem Physician or Medical Facility

____

____

____

Turn Page Over & Complete Other Side>>

Please list any of your child's hospitalizations in the last five years:

Dates of Hospitalization   Where Hospitalized   Reason

____

____

Please list all of your child's current medications:

Medication   Dosage   Frequency   Condition being Treated   Prescribing Physician

____

____

____

For Girls Only: *Has your child had any pregnancies?* ☐No ☐Yes Date(s):_________________________

Miscarriage(s) ☐No ☐Yes Date(s)________________

Abortion(s) ☐No ☐Yes Date(s)________________

Any problem with menstruation? No ☐Yes ____

Please indicate the frequency with which your child/youth has used any of the following substances in the last six months:

Key:

5=Daily 4=4-5 times/week 3=1-3 times/week 2=more than once/month 1=less than once/month 0=never

____Cigarettes   ____Pain Medication   ____Heroine

____ Marijuana   ____ Amphetamines (Speed/Uppers)   ____Ecstasy (XTC)

____Alcohol   ____LSD, PCP or Mushrooms   ____Cocaine, Crack

____Sleeping Pills   ____Caffeine

(amount)____

____Laxatives

____Other____

Has your child ever been treated for drug or alcohol problems? ☐No ☐Yes

*If yes, when and where?*____

Has your child ever attended Al-Anon or Al-Ateen? ☐No ☐Yes

Has anyone ever expressed any concern about your child's use of drugs/alcohol? ☐No ☐Yes

Has anyone ever criticized your child's drinking or drug use? ☐No ☐Yes

Has your child ever expressed feelings of guilt about drinking or drug use? ☐No ☐Yes

Has your child ever had a drink or used drugs first thing in the morning? ☐No ☐Yes

Has your child ever had a DUI? ☐No ☐Yes *If yes, when and where?*____________________________

Has your child ever had an alcohol or drug-related arrest? ☐No ☐Yes *If yes, what was the charge?*

____

Have your child ever been court-ordered to attend an Alcohol Diversion Program? ☐No ☐Yes

*If yes, when and where?*____

Would you like to sign a release allowing the therapist and your physician (PCP) to communicate about your child's concerns and/or medications? ___Yes, ___No, or ___ I'd like to discuss this first.

How did you hear about us? Please check all that apply: ☐ Insurance/Managed Care referral
☐ Internet search ☐ Phone Book ☐ Physician's Office ☐ Friend/Family ☐ Our website
☐ Professional Referral's Name (e.g. therapist, attorney, pastor):

____

☐ Other:

____

Please note below anything else you think would be helpful for us to know about your child's health. Thank you!