SHADOW MOUNTAIN
BEHAVIORAL HEALTH SYSTEM

OUTPATIENT SERVICES
CHILD AND ADOLESCENT HISTORY AND GOALS

Please complete this questionnaire and give it to your child's physician or therapist at your first appointment. This information will help your child's clinician gain an understanding of the problems for which you are requesting our assistance. The form is designed for both children and adolescents, so some questions may not apply to your child.

CHILD'S NAME IN FULL	DATE OF BIRTH	AGE

NAME OF PERSON COMPLETING FORM	RELATIONSHIP TO CHILD	TELEPHONE

RELATIONSHIP	NAME	TELEPHONE
Mother		
Father		
Legal Guardian		
Child lives with		

LIST PROBLEMS THAT RESULTED IN THE REFERRAL

APPROXIMATELY HOW LONG HAVE THE PROBLEMS BEEN NOTICED

DESCRIBE PREVIOUS TREATMENT BY MENTAL HEALTH PROFESSIONALS
(Include use of medications for behavior / emotions)

DATE	NAME OF PROFESSIONAL	TREATMENT	RESPONSE

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CHILD'S DEVELOPMENT

MOTHER'S PREGNANCY

HOW MANY MONTHS WAS THE PREGNANCY?

DURING PREGNANCY	NO	YES	DESCRIBE
Was there any use of prescribed drugs by the mother?			
Were there any significant medical problems or major parental stressors?			
Was there any use of cigarettes by the mother?			
Was there any use of alcohol/illegal drugs by the mother?			

LABOR AND DELIVERY

DELIVERY
☐ Pre-term ☐ Full-term ☐ Vaginal ☐ C-Section

BIRTH WEIGHT
pounds ounces

DESCRIBE ANY COMPLICATIONS

DID THE CHILD EXPERIENCE ANY EARLY MEDICAL PROBLEMS? (SUCKING, BREATHING, JAUNDICE, ETC.)

DEVELOPMENT

ACCOMPLISHMENT	EARLY	NORMAL RANGE	DELAYED	EXPLAIN ANY LOSS OF PREVIOUSLY MASTERED SKILLS
Sit without support of parent		4-6 MONTHS		
Walking		12-15 MONTHS		
Speech (single words)		15-18 MONTHS		

TEMPERAMENT DURING THE PRE-SCHOOL YEARS

BEHAVIOR	NO	YES	DESCRIBE
Fearful			
Shy			
Aggressive			
Hyperactive Active			
Passive			

DESCRIBE ANY OTHER BEHAVIORAL PROBLEMS NOTED DURING THE PRESCHOOL YEARS

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MEDICAL HISTORY

PRIMARY CARE PHYSICIAN	SPECIALISTS

PLEASE DESCRIBE ANY SERIOUS OR LONGSTANDING ILLNESSES THE CHILD HAS EXPERIENCED

HAS THE CHILD EXPERIENCED HEAD INJURY, SEIZURES, LOSS OF CONSCIOUSNESS?

LIST ANY SURGERIES THE CHILD HAS HAD AND THE APPROXIMATE DATES

IS THERE ANY HISTORY OF MEDICAL PROBLEMS THAT RUN IN THE FAMILY (FOR INSTANCE, DIABETES, HEART DISEASE, ETC.)?

IF CHILD IS FEMALE , HAS MENSTRUATION BEGUN
☐ Yes ☐ No

LIST ALL PRESCRIBED MEDICATIONS THE CHILD CURRENTLY RECEIVES

MEDICATION	AMOUNT	HOW OFTEN	PRESCRIBING PHYSICIAN

LIST ANY MEDICATIONS THAT HAVE CAUSED THE CHILD TO EXPERIENCE SEVERE SIDE EFFECTS (BUT NOT ALLERGIC REACTIONS)

LIST ANY MEDICATIONS OR FOODS THAT HAVE CAUSED ALLERGIC REACTIONS (FOR EXAMPLE: RASH, ITCHING, SHORTNESS OF BREATH)

AT WHAT TIME DOES THE CHILD AWAKEN IN THE MORNING?	WHAT IS THE CHILD'S BEDTIME?	DOES THE CHILD APPEAR WELL RESTED? ☐ Yes ☐ No

✓	CHECK SUBSTANCES CHILD HAS USED	AGE FIRST USE	CURRENT AMOUNT USED
	Cigarettes / other forms of nicotine		
	Alcohol		
	Marijuana		
	Cocaine		
	Methamphetamines		
	Other		

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CHILD'S EDUCATION

NAME OF PRESENT SCHOOL	TELEPHONE NUMBER

ADDRESS CITY, STATE, ZIP CODE

SCHOOL COUNSELOR	HOMEROOM TEACHER	GRADE LEVEL

HAS THE CHILD EVER BEEN RETAINED OR HELD BACK A GRADE ☐ NO ☐ YES	REASON	GRADE RETAINED

EXPLAIN ANY SPECIAL EDUCATION OR GIFTED SERVICES THE CHILD HAS RECEIVED

DESCRIBE OVERALL ADJUSTMENT OF DAYCARE/PRESCHOOL

DESCRIBE OVERALL ADJUSTMENT / PERFORMANCE IN KINDERGARTEN

DESCRIBE ADJUSTMENT / PERFORMANCE IN FIRST GRADE

WHAT KINDS OF GRADES DOES THE CHILD USUALLY RECEIVE?	GRADES THIS PAST YEAR HAVE ☐ Worsened ☐ Improved

HAS CHILD EXPERIENCED ANY OF THE FOLLOWING	NO	YES	IF YES, EXPLAIN
Refusal to attend school			
School phobia			
Truancy			
Suspension from school			
Expulsion from school			

DISCUSS ANY OTHER SCHOOL CONCERNS

PLEASE PROVIDE COPIES OF ALL REPORT CARDS, STANDARDIZED TESTS AND ANY TESTING WHICH MAY HAVE BEEN COMPLETED IN AN ACADEMIC OR COUNSELING SETTING

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PEER RELATIONSHIPS / FRIENDSHIPS

APPROXIMATELY HOW MANY FRIENDS DOES THE CHILD HAVE?	DOES THE CHILD HAVE A BEST FRIEND? ☐ Yes ☐ No	FOR HOW LONG?

HAS CHILD DEMONSTRATED ANY OF THE FOLLOWING	NO	YES	DESCRIBE OTHER PEER PROBLEMS
Fight / argue frequently with peers			
Have difficulty making friends			
Have difficulty keeping friends			
Tend to associate with older children			
Tend to associate with younger children			
Tend to associate with children who get into trouble			
Prefer to play with children of the opposite sex			
Get teased by other children			
Is the child a bully			
Do you approve of the child's friends			
Is the adolescent dating			
Is the adolescent sexually active			

ACTIVITIES

LIST ANY ORGANIZATIONS OR ORGANIZED GROUP ACTIVITIES IN WHICH THE CHILD PARTICIPATES (E.G., CHURCH, SPORTS, SCOUTS, ETC.)

LIST ANY UNORGANIZED ACTIVITIES IN WHICH THE CHILD PARTICIPATES (VIDEO GAMES, SKATEBOARDING, ETC.)

APPROXIMATELY HOW MANY HOURS OF TELEVISION DOES THE CHILD WATCH PER WEEK?	APPROXIMATELY HOW MANY HOURS OF HOMEWORK DOES THE CHILD COMPLETE PER NIGHT?	DOES THE CHILD USUALLY COMPLETE HOMEWORK IF ASSIGNED? ☐ Yes ☐ No

HOW DOES THE CHILD OBTAIN ALLOWANCE?

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FAMILY DATA

LIST PARENTAL FIGURES

NAME	AGE	EDUCATION	IN THE HOME		PROFESSION
			YES	NO	
MOTHER					
FATHER					
STEPMOTHER(S)					
STEPFATHER(S)					
OTHER-SPECIFY					

IS THE CHILD ADOPTED ☐ No ☐ Yes	AT WHAT AGE?	WHERE WAS THE CHILD BEFORE ADOPTION?

WHEN WERE BIRTH / ADOPTIVE PARENTS MARRIED	SEPARATED	DIVORCED

IF SEPARATED OR DIVORCED, WHAT WAS THE CHILD'S REACTION?

WHAT IS THE VISITATION/CUSTODY ARRANGEMENTS?

WHO HAS LEGAL CUSTODY	IS THERE ANY ANTICIPATED OR POSSIBLE CHANGE OF CUSTODY AT THIS TIME? ☐ No ☐ Yes	HOW COOPERATIVE ARE THE DIVORCED PARENTS IN MAKING DECISIONS / ARRANGEMENTS?

HOW DOES THE CHILD RELATE TO THE STEP-PARENT(S) AND / OR BOYFRIEND(S) / GIRLFRIEND(S), IF APPLICABLE?

LIST OF SIBLINGS

NAME	AGE	RELATIONSHIP	HOW DO THEY GET ALONG	BEHAVIORAL / EMOTIONAL PROBLEMS
		☐ Brother ☐ Full ☐ Half ☐ Sister ☐ Step ☐ Adoptive		
		☐ Brother ☐ Full ☐ Half ☐ Sister ☐ Step ☐ Adoptive		
		☐ Brother ☐ Full ☐ Half ☐ Sister ☐ Step ☐ Adoptive		
		☐ Brother ☐ Full ☐ Half ☐ Sister ☐ Step ☐ Adoptive		
		☐ Brother ☐ Full ☐ Half ☐ Sister ☐ Step ☐ Adoptive		

DESCRIBE ANY SIBLING-RELATED ISSUES YOU THINK ARE IMPORTANT

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DIFFICULTY	THIS CHILD	FATHER	MOTHER	SISTER	BROTHER	GRANDPARENTS
Agoraphobia / Panic Attacks						
Alcohol / Drug Abuse						
Anxiety						
Antisocial Behavior / Arrests / Incarceration						
Attention Deficit / Hyperactivity Disorder						
Depression						
Eating Disorder						
Loss / Death of Significant Person						
Manic Depression / Bipolar Disorder						
Mental Retardation						
Obsessive Compulsive Disorder						
Schizophrenia						
Tourette's Disease / Tics						
Victim of Physical Abuse						
Victim of Emotional Abuse						
Victim of Sexual Abuse						

STRENGTHS

WHAT IN YOUR OPINION ARE THE CHILD'S STRENGTHS AND ASSETS?

GOALS AND EXPECTATIONS

WHAT TYPE OF SERVICES ARE YOU INTERESTED IN RECEIVING FROM SHADOW MOUNTAIN TO HELP YOUR CHILD OVERSOME THE PROBLEMS THAT BRING YOU TO TREATMENT?

☐ Assessment and consultation ☐ Medication ☐ Individual psychotherapy
☐ Family Therapy ☐ Group therapy with children or adolescents who have similar problems
☐ Specify Other:

WHAT DO YOU WANT TO BE DIFFERENT IN THE CHILD'S LIFE AND RELATIONSHIP AS A RESULT OF RECEIVING TREATMENT?

HOW WILL THE CHILD BE BEHAVING, THINKING, AND FEELING WHEN THE PROBLEM NO LONGER INTERFERS WITH HIS OR HER LIFE?

THIS PATIENT **DOES** **DOES NOT** REQUIRE A PHYSICAL EXAMINATION (**PLEASE CIRCLE ONE**)

REVIEWED BY (CLINICIAN'S SIGNATURE)	CREDENTIALS	DATE