

Child/Adolescent Social and Health History

Client Name (First, MI, Last)	Date of Birth	Today's Date												
Presenting Problem														
Why are you seeking treatment today?														
How long ago did you begin to be troubled by this problem?														
How often do you experience this problem?														
When did you first consult a professional (counselor, physician, social worker, etc.)?														
Symptom Checklist Check All Current Problems														
<input type="checkbox"/> Nutritional/Eating Pattern Changes/Disorders As evidenced by: <table style="width: 100%; margin-top: 5px;"> <tr> <td><input type="checkbox"/> Self-induced Vomiting</td> <td><input type="checkbox"/> Increase in Appetite</td> <td><input type="checkbox"/> Weight Gain</td> </tr> <tr> <td><input type="checkbox"/> Binge Eating</td> <td><input type="checkbox"/> Decrease in Appetite</td> <td><input type="checkbox"/> Weight Loss</td> </tr> <tr> <td><input type="checkbox"/> Use of Laxatives</td> <td><input type="checkbox"/> Excessive Exercising</td> <td><input type="checkbox"/> None</td> </tr> </table>			<input type="checkbox"/> Self-induced Vomiting	<input type="checkbox"/> Increase in Appetite	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Binge Eating	<input type="checkbox"/> Decrease in Appetite	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Use of Laxatives	<input type="checkbox"/> Excessive Exercising	<input type="checkbox"/> None			
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<input type="checkbox"/> Use of Laxatives	<input type="checkbox"/> Excessive Exercising	<input type="checkbox"/> None												
<input type="checkbox"/> Pain Management As evidenced by: <table style="width: 100%; margin-top: 5px;"> <tr> <td><input type="checkbox"/> Pain Interferes with Activities</td> <td><input type="checkbox"/> None</td> </tr> </table>			<input type="checkbox"/> Pain Interferes with Activities	<input type="checkbox"/> None										
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<input type="checkbox"/> Depressed Mood/Sad As evidenced by: <table style="width: 100%; margin-top: 5px;"> <tr> <td><input type="checkbox"/> Loss of Interest in Activities</td> <td><input type="checkbox"/> Hopelessness</td> <td><input type="checkbox"/> Indecisiveness</td> </tr> <tr> <td><input type="checkbox"/> Empty Feeling</td> <td><input type="checkbox"/> Worthlessness</td> <td><input type="checkbox"/> Recurrent Thoughts of Death</td> </tr> <tr> <td><input type="checkbox"/> Fatigue/Loss of Energy</td> <td><input type="checkbox"/> Trouble Concentrating</td> <td><input type="checkbox"/> Feeling Sad or Depressed</td> </tr> <tr> <td><input type="checkbox"/> Thoughts of Harming Yourself</td> <td><input type="checkbox"/> None</td> <td></td> </tr> </table>			<input type="checkbox"/> Loss of Interest in Activities	<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Indecisiveness	<input type="checkbox"/> Empty Feeling	<input type="checkbox"/> Worthlessness	<input type="checkbox"/> Recurrent Thoughts of Death	<input type="checkbox"/> Fatigue/Loss of Energy	<input type="checkbox"/> Trouble Concentrating	<input type="checkbox"/> Feeling Sad or Depressed	<input type="checkbox"/> Thoughts of Harming Yourself	<input type="checkbox"/> None	
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<input type="checkbox"/> Grief Issues As evidenced by: <table style="width: 100%; margin-top: 5px;"> <tr> <td><input type="checkbox"/> Loss of Loved One in Past Year</td> <td><input type="checkbox"/> Other Loss (Describe)</td> <td><input type="checkbox"/> None</td> </tr> </table>			<input type="checkbox"/> Loss of Loved One in Past Year	<input type="checkbox"/> Other Loss (Describe)	<input type="checkbox"/> None									
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<input type="checkbox"/> Anxiety As evidenced by: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Excessive Worry</td> <td style="width: 33%;"><input type="checkbox"/> Irritability</td> <td style="width: 33%;"><input type="checkbox"/> Excessive Checking</td> </tr> <tr> <td><input type="checkbox"/> Restlessness</td> <td><input type="checkbox"/> Compulsions</td> <td><input type="checkbox"/> Strong Fears</td> </tr> <tr> <td><input type="checkbox"/> Obsessions</td> <td><input type="checkbox"/> Difficulty Breathing</td> <td><input type="checkbox"/> Shaking</td> </tr> <tr> <td><input type="checkbox"/> Muscle Tension</td> <td><input type="checkbox"/> Pounding Heart</td> <td><input type="checkbox"/> Excessive Handwashing</td> </tr> <tr> <td><input type="checkbox"/> None</td> <td></td> <td></td> </tr> </table>		<input type="checkbox"/> Excessive Worry	<input type="checkbox"/> Irritability	<input type="checkbox"/> Excessive Checking	<input type="checkbox"/> Restlessness	<input type="checkbox"/> Compulsions	<input type="checkbox"/> Strong Fears	<input type="checkbox"/> Obsessions	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Shaking	<input type="checkbox"/> Muscle Tension	<input type="checkbox"/> Pounding Heart	<input type="checkbox"/> Excessive Handwashing	<input type="checkbox"/> None		
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<input type="checkbox"/> Traumatic Stress As evidenced by: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Recurrent/Intrusive/Distressing Thoughts/Images</td> <td style="width: 33%;"><input type="checkbox"/> Startles Easily</td> <td style="width: 33%;"><input type="checkbox"/> None</td> </tr> <tr> <td><input type="checkbox"/> Recurrent Dreams/Nightmares</td> <td><input type="checkbox"/> Exposure to Traumatic Event</td> <td></td> </tr> </table>		<input type="checkbox"/> Recurrent/Intrusive/Distressing Thoughts/Images	<input type="checkbox"/> Startles Easily	<input type="checkbox"/> None	<input type="checkbox"/> Recurrent Dreams/Nightmares	<input type="checkbox"/> Exposure to Traumatic Event										
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<input type="checkbox"/> Anger/Aggression As evidenced by: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Threatens/Intimidates Others</td> <td style="width: 33%;"><input type="checkbox"/> Physically Hurts People</td> <td style="width: 33%;"><input type="checkbox"/> Use of Weapons</td> </tr> <tr> <td><input type="checkbox"/> Initiates Fights</td> <td><input type="checkbox"/> Physically Hurts Animals</td> <td><input type="checkbox"/> None</td> </tr> </table>		<input type="checkbox"/> Threatens/Intimidates Others	<input type="checkbox"/> Physically Hurts People	<input type="checkbox"/> Use of Weapons	<input type="checkbox"/> Initiates Fights	<input type="checkbox"/> Physically Hurts Animals	<input type="checkbox"/> None									
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<input type="checkbox"/> Oppositional Behaviors As evidenced by: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Loses Temper</td> <td style="width: 33%;"><input type="checkbox"/> Blames Others</td> <td style="width: 33%;"><input type="checkbox"/> Spiteful/Vindictive</td> </tr> <tr> <td><input type="checkbox"/> Argues</td> <td><input type="checkbox"/> Easily Annoyed</td> <td><input type="checkbox"/> None</td> </tr> <tr> <td><input type="checkbox"/> Deliberately Annoys Others</td> <td><input type="checkbox"/> Angry and Resentful</td> <td></td> </tr> </table>		<input type="checkbox"/> Loses Temper	<input type="checkbox"/> Blames Others	<input type="checkbox"/> Spiteful/Vindictive	<input type="checkbox"/> Argues	<input type="checkbox"/> Easily Annoyed	<input type="checkbox"/> None	<input type="checkbox"/> Deliberately Annoys Others	<input type="checkbox"/> Angry and Resentful							
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<input type="checkbox"/> Inattention As evidenced by: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Difficulty Sustaining Attention</td> <td style="width: 33%;"><input type="checkbox"/> Disorganized</td> <td style="width: 33%;"><input type="checkbox"/> Forgetful</td> </tr> <tr> <td><input type="checkbox"/> Trouble Finishing Things</td> <td><input type="checkbox"/> Easily Distracted</td> <td><input type="checkbox"/> None</td> </tr> </table>		<input type="checkbox"/> Difficulty Sustaining Attention	<input type="checkbox"/> Disorganized	<input type="checkbox"/> Forgetful	<input type="checkbox"/> Trouble Finishing Things	<input type="checkbox"/> Easily Distracted	<input type="checkbox"/> None									
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<input type="checkbox"/> None																
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<input type="checkbox"/> Mood Swings/Hyperactivity As evidenced by: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Excessive Movement</td> <td style="width: 33%;"><input type="checkbox"/> Excessive Talking</td> <td style="width: 33%;"><input type="checkbox"/> Rapid or Extreme Changes in Mood</td> </tr> <tr> <td><input type="checkbox"/> Decreased Need for Sleep</td> <td><input type="checkbox"/> Irritability</td> <td><input type="checkbox"/> Inflated Self-Esteem</td> </tr> <tr> <td><input type="checkbox"/> None</td> <td></td> <td></td> </tr> </table>		<input type="checkbox"/> Excessive Movement	<input type="checkbox"/> Excessive Talking	<input type="checkbox"/> Rapid or Extreme Changes in Mood	<input type="checkbox"/> Decreased Need for Sleep	<input type="checkbox"/> Irritability	<input type="checkbox"/> Inflated Self-Esteem	<input type="checkbox"/> None								
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<input type="checkbox"/> Addictive Behaviors As evidenced by: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Gambling</td> <td style="width: 33%;"><input type="checkbox"/> Internet</td> <td style="width: 33%;"><input type="checkbox"/> Shopping</td> </tr> <tr> <td><input type="checkbox"/> Pornography</td> <td><input type="checkbox"/> None</td> <td></td> </tr> </table>		<input type="checkbox"/> Gambling	<input type="checkbox"/> Internet	<input type="checkbox"/> Shopping	<input type="checkbox"/> Pornography	<input type="checkbox"/> None										
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Client Name (First, MI, Last)	Date of Birth
<input type="checkbox"/> Sleep Problems As evidenced by: <input type="checkbox"/> Difficulty Falling or Staying Asleep <input type="checkbox"/> Sleepwalking <input type="checkbox"/> Frequent Nightmares <input type="checkbox"/> Excessive Sleepiness <input type="checkbox"/> None	
<input type="checkbox"/> Wetting or Soiling As evidenced by: <input type="checkbox"/> Daytime <input type="checkbox"/> Nighttime <input type="checkbox"/> None	
<input type="checkbox"/> Sexual Orientation and/or Gender Expression <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning Other relevant information:	
<input type="checkbox"/> Stressors	
<input type="checkbox"/> Other As evidenced by: <input type="checkbox"/> Obsessions <input type="checkbox"/> Compulsions <input type="checkbox"/> Other:	
Pertinent Developmental Issues	
Mother's Pregnancy History (include prenatal exposure to alcohol, tobacco, and other drugs) <input type="checkbox"/> No Problems Reported	
Infancy (Ages 0-1) <input type="checkbox"/> No Problems Reported	
Preschool (Ages 2-4) <input type="checkbox"/> No Problems Reported	
Childhood (Ages 5-12) <input type="checkbox"/> No Problems Reported	
Adolescent (Ages 13-17) <input type="checkbox"/> No Problems Reported	

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Living Situation

Parent's Home <input type="checkbox"/> Rent <input type="checkbox"/> Own	**Residential Care/Treatment Facility <input type="checkbox"/> Hospital <input type="checkbox"/> Temporary Housing <input type="checkbox"/> Residential Care <input type="checkbox"/> Nursing Home		
**Other <input type="checkbox"/> Friend's Home <input type="checkbox"/> Relative's/Guardian's Home <input type="checkbox"/> Foster Care Home <input type="checkbox"/> Respite Care <input type="checkbox"/> Homeless Living with Friend <input type="checkbox"/> Homeless in Shelter/No Residence <input type="checkbox"/> Jail/Prison <input type="checkbox"/> Other:			

****Identify Facility or Person's Name**

Primary Household

Household Member Names	Relationship To Client	Age	Occupation/School	Level of Education	Quality of Relationship (Staff Use Only)

Secondary Household

Does client live in more than one household?

No If no, skip to "Additional Family Members"

Yes If yes, complete the secondary household information below

Household Member Names	Relationship To Client	Age	Occupation/School	Level of Education	Quality of Relationship (Staff Use Only)

Secondary Household Street Address (if different from client's address listed on Demographic Information Form)

Family Members Who Live in Both Households

Client only Client and (List):

Additional Family Members (i.e., parents or siblings not living in primary or secondary households)

No parents or siblings other than those listed in primary or secondary households

Custody and Parenting Plan

Lives with both parents (biological or adoptive) in same household or with widowed parent

Other (describe):

Client Name (First, MI, Last)	Date of Birth
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Family Environment/Relationships

Parent-Child (Client) Relationship(s): Not Applicable P = Primary Household S = Secondary Household B = Both

Comment on Parent-Child Relationship(s): (could include parent-child conflict, parent supervision and monitoring of child, cooperation between parents regarding child rearing, parent positive activities with child, parent satisfaction with relationship, child satisfaction with relationship(s))

Sibling-Child (Client) Relationship(s): No Siblings P = Primary Household S = Secondary Household B = Both

Comment on Sibling-Child Relationship(s): (could include sibling-child conflict, positive activities with child, sibling satisfaction with relationship, child satisfaction with relationship(s))

Parent Marital or Couples Relationship(s): Not Applicable at this time P = Primary Household S = Secondary Household B = Both

Comment on Parent Marital or Couples Relationship(s): (could include marital or couples conflict, marital or couples satisfaction with relationship(s))

Family Concerns

			If yes, indicate relationship to child:
Family Member Alcohol Abuse:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Family Member Drug Abuse:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Family Member Mental Health Problems:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Family Member Health Problems:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Family Member Disability:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Family Member Legal Issues:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Family Member Financial Concerns	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

Other (describe)

Comment on other family concerns and information relating to financial status (specify problems that impact client's needs)

Client Name (First, MI, Last)	Date of Birth
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School Functioning

Educational Classification

Name of School:	Current Grade:
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Regular Education Classification, No Special Services

Yes No If no, check all that apply

- | | | |
|--|--|---|
| <input type="checkbox"/> 01 Multiple disabilities (not deaf-blind) | <input type="checkbox"/> 06 Orthopedic Impairment | <input type="checkbox"/> 11 Autism |
| <input type="checkbox"/> 02 Deaf-Blindness | <input type="checkbox"/> 07 Emotional Disturbance (SBH) | <input type="checkbox"/> 12 Traumatic Brain Injury |
| <input type="checkbox"/> 03 Deafness (hearing impairment) | <input type="checkbox"/> 08 Mental Retardation (DH) | <input type="checkbox"/> 13 Other Health Impaired (Major) |
| <input type="checkbox"/> 04 Visual Impairment | <input type="checkbox"/> 09 Specific Learning Disability | <input type="checkbox"/> 14 Other Health Impaired (Minor) |
| <input type="checkbox"/> 05 Speech or Language Impairment | <input type="checkbox"/> 10 Preschoolers with a Disability | <input type="checkbox"/> 15 Current 504 Plan |
| <input type="checkbox"/> Other: | | |

Comments on Educational Classification/Placement (please indicate if client is home schooled, in gifted program, etc.)

Grades

School Proficiency/Achievement Exams/Ohio Graduation Tests (OGT)

Most Recent Exams: Grade level taken _____ OGT (reading and math only) Has not taken these exams

Exams Taken	Results		
Reading	<input type="checkbox"/> Passed	<input type="checkbox"/> Did Not Pass	<input type="checkbox"/> Unknown
Math	<input type="checkbox"/> Passed	<input type="checkbox"/> Did Not Pass	<input type="checkbox"/> Unknown
Citizenship	<input type="checkbox"/> Passed	<input type="checkbox"/> Did Not Pass	<input type="checkbox"/> Unknown or N/A
Science	<input type="checkbox"/> Passed	<input type="checkbox"/> Did Not Pass	<input type="checkbox"/> Unknown or N/A
Writing	<input type="checkbox"/> Passed	<input type="checkbox"/> Did Not Pass	<input type="checkbox"/> Unknown or N/A

Other Test Results (IQ, Achievement, Developmental)

No other test results reported

Attendance

Not a problem

Previous Grade Retentions

None reported

Client Name (First, MI, Last)	Date of Birth
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Suspensions/Expulsions
 None reported

Other Academic School Concerns (including performance/behavioral problems due to AOD use)
 None reported

Barriers to Learning
 None reported Inability to Read or Write Other:

Peer Relationships/Social Functioning

Special Communication Needs
 None reported TDD/TTY Device Sign Language Interpreter Assistive Listening Device(s)
 Language Interpreter Services Needed/Other Spoken Language: _____
 Other: _____

Employment

Not Pertinent – Skip this section

Currently Employed? Yes No If yes, name of employer
Name of Employer: _____ Job Title: _____

Employment Interests/Skills/Concerns

Client Name (First, MI, Last)	Date of Birth
Legal History	
Current Legal Status	
<input type="checkbox"/> None Reported <input type="checkbox"/> On Probation <input type="checkbox"/> Detention <input type="checkbox"/> On Parole <input type="checkbox"/> AoD Related Legal Problems <input type="checkbox"/> Awaiting Charge <input type="checkbox"/> Court Ordered to Treatment <input type="checkbox"/> Others	
History of Legal Charges	
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, check and describe <div style="margin-left: 400px;"> <input type="checkbox"/> Status Offense (e.g., Unruly) <input type="checkbox"/> Delinquency </div>	
Name of Probation/Parole Officer (if applicable)	
Adjudications	
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe:	
Detentions or Incarcerations	
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe:	
Civil Proceedings	
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe:	
Domestic Relations Court Involvement	
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe:	
Juvenile Court Involvement (related to child abuse, neglect, or dependency)	Caseworker Name (if applicable)
Current: <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____	
Past: <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____	
Children's Protective Services Involvement with Family	
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe:	
Name of Children's Protective Services Caseworker(s) Assigned to Family (if applicable)	
<input type="checkbox"/> None Reported	
Name of Guardian ad Litem (GAL) or Court Appointed Special Advocate (CASA) Assigned to Family (if applicable)	
<input type="checkbox"/> None Reported	

Client Name (First, MI, Last)	Staff Use Only: Client Number	Date of Birth
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Child/Adolescent Health History Questionnaire

This form should be completed as fully as possible by client, but reviewed by medical or clinical staff

Has the child had any of the following health problems?

	Now	Past	Never	What Treatment Was Received and Date(s)
Anemia				
Arthritis				
Asthma				
Bleeding Disorder				
Blood Pressure (high or low)				
Bone/Joint Problems				
Cancer				
Cirrhosis/Liver Disease				
Diabetes				
Epilepsy/Seizures				
Eye Disease/Blindness				
Fibromyalgia/Muscle Pain				
Glaucoma				
Headaches				
Head Injury/Brain Tumor				
Hearing Problems/Deafness				
Heart Disease				
Hepatitis/Jaundice				
Kidney Disease				
Lung Disease				
Menstrual Pain				
Oral Health/Dental				
Stomach/Bowel Problems				
Stroke				
Thyroid				
Tuberculosis				
AIDS/HIV				
Sexually Transmitted Disease				
Learning Problems				
Speech Problems				
Anxiety				
Bipolar Disorder				
Depression				
Eating Disorder				
Hyperactivity/ADD				
Schizophrenia				
Sexual Problems				
Sleep Disorder				
Suicide Attempts/Thoughts				
Dementia				
Obesity				
Other:				

Please note family history of any of the above conditions and client's relationship to that family member

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Current Medication Information
(medical and psychiatric prescription/OTC/herbal)

None Reported

Medication	Rationale	Dosage/Route/Frequency	How is it Working?

Primary Care Physician (name, phone no., and address)

Date of Last Physical Exam

Other Prescribing Physician(s) (name, phone no., and address)

Past Psychiatric Medications

None Reported

Past Psychiatric Medications	How did it work/Reason for Stopping/Adverse Reactions

Has the child had medical hospitalization/surgical procedures in the last 3 years?

No Yes If yes, complete information below

Hospital	City	Date	

Allergies/Drug Sensitivities

None

Food (specify)

Medicine (specify)

Other (specify)

Pregnancy History Not Pertinent

Currently Pregnant? (If yes, expected delivery date) <input type="checkbox"/> No <input type="checkbox"/> Yes Expected Delivery Date	Receiving Prenatal Healthcare? (If yes, indicate provider) <input type="checkbox"/> No <input type="checkbox"/> Yes Provider
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Currently Breastfeeding? No Yes

Last Menstrual Period Date

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Medical Information

Indicate how many times in the past 12 months the child has used these medical services:

_____ Hospital admissions	_____ Emergency room visits
_____ Regular visits to doctor	_____ Regular visits to dentist

Has the child had any of the following symptoms in the past 60 days? (please check all that apply)

<input type="checkbox"/> Ankle Swelling	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Tingling in Arms and/or Legs
<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Tremor
<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Falling	<input type="checkbox"/> Numbness	<input type="checkbox"/> Urination Difficulty
<input type="checkbox"/> Breathing Difficulty	<input type="checkbox"/> Gait Unsteadiness	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Hair Change	<input type="checkbox"/> Penile Discharge	<input type="checkbox"/> Vision Changes
<input type="checkbox"/> Confusion	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Pulse Irregularity	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Consciousness Loss	<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other:
<input type="checkbox"/> Constipation	<input type="checkbox"/> Memory Problems	<input type="checkbox"/> Shakiness	
<input type="checkbox"/> Coughing	<input type="checkbox"/> Mole/Wart Changes	<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> Other:
<input type="checkbox"/> Cramps	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Sweats (night)	

Immunizations – Has the child had or been immunized for the following diseases? (please check all that apply)

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> German Measles	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Measles
<input type="checkbox"/> Mumps	<input type="checkbox"/> Polio	<input type="checkbox"/> Small Pox	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Other:

Immunizations Within the Past Year

Height	Has client's weight changed in the past year? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, by how much (+ or -): _____
Weight	

Do you use any complementary health approaches with your child (i.e.: meditation, yoga, nutrition, etc.)?

Nutritional Screening

No Problem	Eating	Drinking	Appetite
<input type="checkbox"/>	<input type="checkbox"/> More <input type="checkbox"/> Less <input type="checkbox"/> Not Eating	<input type="checkbox"/> More <input type="checkbox"/> Less <input type="checkbox"/> Takes Liquids Only	<input type="checkbox"/> Increased <input type="checkbox"/> Decreased
	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Trouble Chewing or Swallowing

Special Diet	Other

Client Name (First, MI, Last)	Date of Birth
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Pain Screening

Does pain currently interfere with the child's activities? (if yes, how much does it interfere with these activities [please check])

No
 Yes
 Not at all
 Mildly
 Moderately
 Severely
 Extremely

Please indicate the source of the pain

Substance Use History/Current Use

(Please check and complete appropriate columns)

Which of the following has the child used?	Age first used	Age last used	Frequency of use
<input type="checkbox"/> Beer			
<input type="checkbox"/> Wine			
<input type="checkbox"/> Liquor			
<input type="checkbox"/> Heroin			
<input type="checkbox"/> Barbiturates			
<input type="checkbox"/> Amphetamines			
<input type="checkbox"/> Crack			
<input type="checkbox"/> Cocaine			
<input type="checkbox"/> Marijuana/Hashish			
<input type="checkbox"/> LSD			
<input type="checkbox"/> Inhalants			
<input type="checkbox"/> PCP			
<input type="checkbox"/> MDMA (XTC)			
<input type="checkbox"/> Prescription drugs off the street			
<input type="checkbox"/> Non-prescription drugs by injection			
<input type="checkbox"/> Other			

Caffeine

Nicotine

_____ Cups of caffeinated coffee per day

_____ Packs of cigarettes per day

_____ Cups of caffeinated tea per day

_____ Other nicotine products per day

_____ Cups of caffeinated soft drinks per day

_____ Other Use:

_____ Ounces of chocolate per day

Print Name of Person Completing This Questionnaire	Signature of Person Completing This Questionnaire	Date
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Clinician Reviewer Comments, Recommendations or Referrals

Recommendations shared with client?

No
 Yes
 If yes, client's response:

If no, how will recommendations be shared with client?

Print Name of Clinician	Signature of Clinician	Date
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