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

☐ **Nutritional/Eating Pattern Changes/Disorders**

As evidenced by:

☐ Self-induced Vomiting	☐ Increase in Appetite	☐ Restricted Eating
☐ Binge Eating	☐ Decrease in Appetite	☐ Weight Gain (+ _________ lbs.)
☐ Use of Laxatives	☐ Excessive Exercising	☐ Weight Loss (- __________ lbs.)
☐ None		

☐ **Pain Management - Pain Interferes with Activities:**

☐ Not at all ☐ Mildly ☐ Moderately ☐ Severely ☐ Extremely

Source of Pain:

☐ **Depressed Mood/Sad**

As evidenced by:

☐ Loss of Interest in Activities	☐ Hopelessness	☐ Indecisiveness
☐ Empty Feeling	☐ Worthlessness	☐ Recurrent Thoughts of Death
☐ Fatigue/Loss of Energy	☐ Trouble Concentrating	☐ Feeling Sad or Depressed
☐ Thoughts of Harming Yourself	☐ None	

☐ **Grief Issues**

As evidenced by:

☐ Loss of Loved One in Past Year ☐ Other Loss (Describe) ☐ None

Client Name (First, MI, Last)	**Date of Birth**

☐ **Anxiety**
As evidenced by:

☐ Excessive Worry	☐ Irritability	☐ Excessive Checking
☐ Restlessness	☐ Compulsions	☐ Strong Fears
☐ Obsessions	☐ Difficulty Breathing	☐ Shaking
☐ Muscle Tension	☐ Pounding Heart	☐ Excessive Handwashing
☐ None		

☐ **Traumatic Stress**
As evidenced by:

☐ Recurrent/Intrusive/Distressing Thoughts/Images	☐ Startles Easily	☐ None
☐ Recurrent Dreams/Nightmares	☐ Exposure to Traumatic Event	

☐ **Anger/Aggression**
As evidenced by:

☐ Threatens/Intimidates Others	☐ Physically Hurts People	☐ Use of Weapons
☐ Initiates Fights	☐ Physically Hurts Animals	☐ None

☐ **Oppositional Behaviors**
As evidenced by:

☐ Loses Temper	☐ Blames Others	☐ Spiteful/Vindictive
☐ Argues	☐ Easily Annoyed	☐ None
☐ Deliberately Annoys Others	☐ Angry and Resentful	

☐ **Inattention**
As evidenced by:

☐ Difficulty Sustaining Attention	☐ Disorganized	☐ Forgetful
☐ Trouble Finishing Things	☐ Easily Distracted	☐ None

☐ **Impulsivity**
As evidenced by:

☐ Difficulty Resisting Impulses	☐ Trouble Waiting for Turn	☐ Frequently Interrupts
☐ None		

☐ **Disturbed Reality Contact**
As evidenced by:

☐ Hears Voices Others Don’t Hear	☐ Seeing Things Others Don’t See	☐ None

☐ **Mood Swings/Hyperactivity**
As evidenced by:

☐ Excessive Movement	☐ Excessive Talking	☐ Rapid or Extreme Changes in Mood
☐ Decreased Need for Sleep	☐ Irritability	☐ Inflated Self-Esteem
☐ None		

☐ **Addictive Behaviors**
As evidenced by:

☐ Gambling	☐ Internet	☐ Shopping
☐ Pornography	☐ None	

Client Name (First, MI, Last)	**Date of Birth**

☐ **Sleep Problems**
As evidenced by:
☐ Difficulty Falling or Staying Asleep ☐ Sleepwalking ☐ Frequent Nightmares
☐ Excessive Sleepiness ☐ None

☐ **Wetting or Soiling**
As evidenced by:
☐ Daytime ☐ Nighttime ☐ None

Sexual Orientation and/or Gender Expression

☐ **Stressors**

☐ **Other**

Pertinent Developmental Issues

Mother's Pregnancy and Delivery History (include prenatal exposure to alcohol, tobacco, and other drugs)
☐ No Problems Reported

Motor Development (Were there delays in motor development milestones – i.e.: holding head up, rolling over, walking, using utensils, dressing self, etc)
☐ No Problems Reported/Normal Development

Speech and Language (Were there delays in speech & language development – i.e.: responding to sounds, cooing, babbling, understanding words, speaking, etc or have they had any physical or occupational therapy)
☐ No Problems Reported/Normal Development

Other Developmental Factors/Concerns or Significant Events
☐ No Problems Reported

How do the identified concerns impact current functioning?
☐ No Problems Reported

Client Name (First, MI, Last)	**Date of Birth**

Living Situation

Current Living Arrangement**

☐ Parent's home(rent or own) ☐ Friend's Home ☐ Relative's/Guardian's Home ☐ Foster Care Home ☐ Respite Care
☐ Homeless Living with Friend ☐ Homeless in Shelter/No Residence ☐ Residential Care ☐ 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 child 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**

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:	☐ No	☐ Yes	
Family Member Drug Abuse:	☐ No	☐ Yes	
Family Member Mental Health Problems:	☐ No	☐ Yes	
Family Member Health Problems:	☐ No	☐ Yes	
Family Member Disability:	☐ No	☐ Yes	
Family Member Legal Issues:	☐ No	☐ Yes	
Family Member Financial Concerns	☐ No	☐ 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**

School Functioning

Educational Classification

Name of School:	Current Grade:

Are there any special services or educational classifications: ☐ No ☐ Yes   Is there a current IEP? ☐ No ☐ Yes –provide copy

If Yes, check all that apply

☐ 01 Multiple disabilities (not deaf-blind)	☐ 06 Orthopedic Impairment	☐ 11 Autism
☐ 02 Deaf-Blindness	☐ 07 Emotional Disturbance (SBH)	☐ 12 Traumatic Brain Injury
☐ 03 Deafness (hearing impairment)	☐ 08 Developmental Disability	☐ 13 Other Health Impaired (Major)
☐ 04 Visual Impairment	☐ 09 Specific Learning Disability	☐ 14 Other Health Impaired (Minor)
☐ 05 Speech or Language Impairment	☐ 10 Preschoolers with a Disability	☐ 15 Current 504 Plan – provide copy
☐ Other:		

Comments on Educational Classification/Intellectual functioning and learning ability (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	☐ Passed	☐ Did Not Pass	☐ Unknown
Math	☐ Passed	☐ Did Not Pass	☐ Unknown
Social Studies	☐ Passed	☐ Did Not Pass	☐ Unknown or N/A
Science	☐ Passed	☐ Did Not Pass	☐ Unknown or N/A
Writing	☐ Passed	☐ Did Not Pass	☐ Unknown or N/A

Other Test Results (IQ, Achievement, Developmental)

☐ No other test results reported

Attendance

☐ Not a problem

Previous Grade Retentions

☐ None reported

Suspensions/Expulsions

☐ None reported

Client Name (First, MI, Last) | **Date of Birth**

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 Technology

☐ 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

Legal History

Current Legal Status

☐ None Reported ☐ On Probation ☐ Detention ☐ On Parole

☐ AOD Related Legal Problems ☐ Awaiting Charge ☐ Court Ordered to Treatment ☐ Others

History of Legal Charges

☐ No ☐ Yes If yes, check and describe ☐ Status Offense (e.g., Unruly)

☐ Delinquency

Name of Probation/Parole Officer (if applicable)

Children's Protective Services Involvement with Family

☐ Past ☐ Present ☐ None If past/present, describe:

Name of Children's Protective Services Caseworker(s) Assigned to Family (if applicable)

☐ None Reported

Name of Guardian ad Litem (GAL) or Court Appointed Special Advocate (CASA) Assigned to Family (if applicable)

☐ None Reported

Client Name (First, MI, Last)	**Date of Birth**

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

Client Name (First, MI, Last)	**Date of Birth**

Current Medication Information

(medical and psychiatric prescription/OTC/herbal)

☐ None Reported

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

Primary Care Physician or other similar medical practitioner (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/Medication Adverse Reactions/ Sensitivities

☐ None ☐ Food (specify) ☐ Medicine (specify) ☐ Other (specify)

Pregnancy History ☐ Not Pertinent

Currently Pregnant? (If yes, expected delivery date)

☐ No ☐ Yes Expected Delivery Date

Receiving Prenatal Healthcare? (If yes, indicate provider)

☐ No ☐ Yes Provider

Currently Breastfeeding? ☐ No ☐ Yes

Last Menstrual Period Date

Client Name (First, MI, Last)	**Date of Birth**

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)

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

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

☐ Chicken Pox	☐ Diphtheria	☐ German Measles	☐ Hepatitis B	☐ Measles
☐ Mumps	☐ Polio	☐ Small Pox	☐ Tetanus	☐ Other:

Immunizations Within the Past Year

Height	**Weight**

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

Does the child have any other physical disabilities or disorders that this questionnaire has not addressed? If so, please list. How are these disorders currently interfering with their life?

Nutritional Screening

No Problem	**Eating**			**Drinking**			**Appetite**	
☐	☐ More	☐ Less	☐ Not Eating	☐ More	☐ Less	☐ Takes Liquids Only	☐ Increased	☐ Decreased

☐ Nausea

☐ Vomiting

☐ Trouble Chewing or Swallowing

Special Diet	**Other**

Client Name (First, MI, Last)	**Date of Birth**

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
☐ Beer			
☐ Wine			
☐ Liquor			
☐ Heroin			
☐ Barbiturates			
☐ Amphetamines			
☐ Crack			
☐ Cocaine			
☐ Marijuana/Hashish			
☐ LSD			
☐ Inhalants			
☐ PCP			
☐ MDMA (XTC)			
☐ Prescription drugs off the street			
☐ Non-prescription drugs by injection			
☐ Other			

Caffeine	**Tobacco/Nicotene**
______ Cups of caffeinated coffee per day	______ Packs of cigarettes per day
______ Cups of caffeinated tea per day	______ Other tobacco products per day
______ Cups of caffeinated soft drinks per day	______ Vaping/e-cigarettes
______ Ounces of chocolate per day	______ Other Use:

Social Needs Screening

1. What is your living situation today?[1]

- [ ] I have a steady place to live
- [ ] I have a place to live today but **I am worried** about losing it in the future
- [ ] I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park).

2. Think about the place you live. Do you have problems with any of the following?[2]

- [ ] Pests such as bugs, ants or mice
- [ ] Mold
- [ ] Lead paint or pipes
- [ ] Lack of heat
- [ ] Oven or stove not working
- [ ] Smoke detectors missing or not working
- [ ] Water leaks
- [ ] None of the above

3. Within the last 12 months, you worried that your food would run out before you got money to buy more.[3]

- [ ] Often true
- [ ] Sometimes true
- [ ] Never true

4. Within the last 12 months, the food you bought just didn't last and you didn't have money to get more.[3]

- [ ] Often true
- [ ] Sometimes true
- [ ] Never true

5. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?[1]

- [ ] Yes
- [ ] No

6. In the past 12 months has the electric, gas, oil or water company threatened to shut off services in your home?[4]

- [ ] Yes
- [ ] No
- [ ] Already shut off

7. How often does anyone, including family and friends, physically hurt you?[5]

- [ ] Never (1)
- [ ] Rarely (2)
- [ ] Sometimes (3)
- [ ] Fairly often (4)
- [ ] Frequently (5)

8. How often does anyone, including family and friends, insult or talk down to you?[5]

- [ ] Never (1)
- [ ] Rarely (2)
- [ ] Sometimes (3)
- [ ] Fairly often (4)
- [ ] Frequently (5)

9. How often does anyone, including family and friends, threaten you with harm?[5]

- [ ] Never (1)
- [ ] Rarely (2)
- [ ] Sometimes (3)
- [ ] Fairly often (4)
- [ ] Frequently (5)

10. How often does anyone, including family and friends, scream or curse at you?[5]

- [ ] Never (1)
- [ ] Rarely (2)
- [ ] Sometimes (3)
- [ ] Fairly often (4)
- [ ] Frequently (5)

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[1] National Association of Community Health Centers and Partner, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures (2017). PREPARE. https://www.nachc.org/research-and-data/prapare/

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[3] Hager, E.R., Quigg, A.M., Black, M.M., Coleman, S.M., Heeren, T., Rose-Jacobs, R., Cook, J.T., Ettinger de Cuba, S. E., Casey, P.H., Chilton, M., Cutts, D.B., Myers A.F., Frank, D. A. (2010). Develoment and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. Doi:10.1542/peds.2009-3146

[4] Cook, J.T., Frank, D.A,, Casey, P.H>, Rose-Jacobs, R.,Black, M.M.. Chilton,M.,…Cutts, D.B.(2008). A Brief Indication of Household Energy Security: Associations with Food Security, Child Health, and Child Development in US Infants and Toddlers. Pediatrics, 122(4), 867-875. Doi:10.1542/peds.2008-0286

[5] Sherin, K.M., Sincacore, J.M., Li, X. Q., Zitter, R.E., & Shakil, A. (1998). HITS: a Short Domestic Violence Screening Tool for Use in a Family Practice Setting. Family Medicine, 30(7), 508-512

Client Name (First, MI, Last)	**Date**

Please sign below

Print Name of Person Completing This Questionnaire	**Signature of Person Completing This Questionnaire**	**Date**

Clinician Reviewer Comments, Recommendations and/or Referrals

Comments:

Social Needs Screening Results:
(Question 1-6: Underlined answers indicate a need. For questions 7-10: score of 11 or more when the numerical answers are added may indicate safety issues.)

- ☐ No significant social needs noted
- ☐ Housing instability
- ☐ Food insecurity
- ☐ Transportation problems
- ☐ Utility needs
- ☐ Safety issues

Recommendations:

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**