Rappahannock Area Community Services Board

Proudly serving the City of Fredericksburg and the Counties of Caroline, King George, Spotsylvania, and Stafford since 1970

Administration/Executive Director: 600 Jackson Street ● Fredericksburg, VA 22401● 540-373-3223 ● Fax: 540-371-3753 ● www.racsb.state.va.us

CHILD AND ADOLESCENT HISTORY FORM

Child and Adolescent History Form

CONFIDENTIALITY

All of the information that you provide in this form is strictly confidential. It cannot be released to anyone without your specific written permission.

REQUEST FOR OTHER INFORMATION

In addition to completing this lengthy but important form, please provide us with copies of all previous evaluations, reports, psychological testing, medical records, school records, report cards you have available. Please bring them to your first appointment.

DIRECTIONS

- This history form is the cornerstone of your child's clinical record. Therefore, we ask that you take as much time as you need to complete it but bring it to your first appointment (or next appointment).
- **Dates:** Please give the year and, if possible, the month for requested dates. Exact dates are not needed.
- **Question Types:** This form has various question types. Please complete as best as you can. Please feel free to give as much information as you like.
- **Additional Space:** The last page has room to answer questions you may not have room for. Refer to the page number and section.
- **Blanks:** Please do not leave any questions blank. Instead please mark None, N/A (for not applicable), or "?" if you do not know the answer.
- Thank you for your patience and effort.

PERSON COMPLETING FORM _____ **TODAY'S DATE**_____

Relationship to child _____

CHILD INFORMATION

Full Name _____ Date of Birth _____ Age_____ Sex___

Home Address_____ Home Phone _____

_____ Other Phone _____

REFERRAL SOURCE

Name _____ (for first two choices below)

Type:

- ❑ Primary Care Physician
- ❑ Other Mental Health Provider
- ❑ Self
- ❑ Friend
- ❑ Phone Book/Advertisement
- ❑ Insurance Company
- ❑ Other _____

Please describe how your referral to us came about.

_____

_____

_____

_____

HOME SITUATION

Child primarily lives with:

- ❑ Biological Mother
- ❑ Biological Father
- ❑ Adoptive Mother
- ❑ Adoptive Father
- ❑ Stepmother
- ❑ Stepfather
- ❑ Foster Parents
- ❑ Other Guardian Parents

Please list names, ages, relationship of <u>all</u> who live with child

Name	**Age**	**Relationship**

Custody:

Biological mother's name _____

Biological father's name _____

Who is the child's legal guardian(s)? _____

Who has custody? _____

Please describe terms of visitation. _____

_____

What is the actual visitation pattern? _____

_____

If foster care, please describe circumstances. _____

Caseworker's _____

Name _____ _____

Phone _____ _____

Does the child know these circumstances? ❑ Yes ❑ No

If adopted, does the child know about the adoption? ❑ Yes ❑ No

Housing:

Type of Housing:

- ❑ Single Family House
- ❑ Apartment/Townhome
- ❑ Mobile Home
- ❑ Motel/Shelter

Number of bedrooms _____

Does child share a room? ❑ Yes ❑ No

With whom? _____

Is this ❑ parent's home?

Or ❑ staying with friend or relative?

Other important relationships:

Please list other people important in the child's life, people who have regular contact or influence. This list may include grandparents, siblings outside the home, sitters/daycare providers, etc.

Name	**Relationship**

YOUR MAIN CONCERNS

Description:

Please describe as specifically as possible the child's major problems that have led you to seek consultation with us at this time.

Problem List:

Please list the problems identified above, and others you think of, from most severe to least severe.

	Problem	**Date first noticed (approx)**
1.		
2.		
3.		
4.		
5.		

Causes and Triggers:

Referring to the problem number above, please describe what you believe to be the causes of these problems and identify any situations that trigger or worsen the problems. (For example: A learning disorder in spelling may cause frustration and anger triggered by spelling homework).

1.

2.

3.

4.

5.

Related Stresses and Changes:

Have there been any changes or stressful situations lately (new baby sibling, moves, change in schools, change in visitation pattern, any traumatic events or losses, divorce of parents, etc.)?

Impact of Problems:

How have these problems impacted your child and family?

School behavior, grades, and peer relationships:

Home behavior and family relationships:

Neighborhood/community relationships, legal problems:

If there are any legal issues please specify charges, status, consequences, future court processes, dates if known.

GOALS FOR EVALUATION AND TREATMENT

Please list specific goals you have for your child's evaluation and treatment. What do you hope the evaluation and treatment will accomplish? Please prioritize these goals. Include if you expect the evaluation to be used in court proceedings.

1.

2.

3.

4.

5.

PAST MENTAL HEALTH HISTORY

Current Treatment:

Please identify current treatment providers (therapists, psychiatrists, other physician, school counselor, pastoral counselor etc.), type of treatment (therapy, family therapy, medication, etc.), and when treatment started.

	Clinician Providing Treatment	Type of Treatment	Date Began
1.			
2.			
3.			

Past Treatment:

Please identify past treatment providers similar to those above:

	Clinician Providing Treatment	Type of Treatment	Approximate Dates
1.			
2.			
3.			
4.			
5.			

Past Psychiatric Hospitalizations:

Please list past hospitalizations, residential placements, or other treatment programs where the child stayed outside of the home. If more than once to same facility, just list once with approximate dates.

	Name of Facility	City/St if not local	Date
1.			
2.			
3.			
4.			

MEDICATION HISTORY

Allergies and Adverse Reactions:

Please identify medication allergies (rashes, breathing problems, etc.) or adverse reactions (severe side effects) and describe. Include all medicines, not just psychiatric.

Current Medications:

Please list current medications the child takes. Please list psychiatric medications first followed by routine medical medicines, then list frequent (monthly or more) "PRN" or "as needed" medicines (e.g. Tylenol). Please identify approximate start date for daily medicines. Please also identify herbal, "natural" medicines, or vitamins.

Medicine	**Dose**	**Date Started**	**Benefits**	**Suspected Side Effects**

Past Medications:

Please list past psychiatric medicines used. Start with the most recent before the above current medicines. List approximate dates used. List starting and maximum doses if possible. If you need more space, please use the last page or provide a separate sheet. For example:

(Ritalin 5 mg TID to 15 mg TID 1/00 – 8/02 helped hyperactivity poor sleep and appetite)

Medicine	**Doses**	**Dates Used**	**Benefits**	**Suspected Side Effects**

PAST MEDICAL HISTORY

Primary Care Physician:

Name _____ Approximate date last seen _____
Address _____ Any current conditions treated:
_____ _____
Phone _____ _____
Fax if known _____

Other Physician/Specialist:

Name _____ Approximate date last seen _____
Address _____ Conditions treated:
_____ _____
Phone _____ _____
Fax if known _____

Other Physician/Specialist:

Name _____ Approximate date last seen _____
Address _____ Conditions treated:
_____ _____
Phone _____ _____
Fax if known _____

Medical Conditions:

Please identify any significant problems with conception, pregnancy, or delivery. (e.g. use of fertility agent, "high risk" status, exposure to toxic substances, premature, delayed, or emergency delivery, NICU).

Please identify any physical handicaps, birth defects, vision, speech, or hearing problems.

Please identify any problems of early childhood (e.g. feeding problems, "failure to thrive", apnea, very high fever, delay in developmental milestones = crawling, walking, toilet training, dressing, coordination, etc.)

Please identify any chronic medical conditions requiring ongoing care. (e.g. diabetes, asthma, hemophilia, etc.)

Please identify any unusual diseases or infections (meningitis, encephalitis, tuberculosis, etc.)

Please identify any neurological problems (e.g. seizures) or significant head injury (e.g. loss of consciousness).

Please identify any intermittent but significant medical problems (e.g. severe menstrual problems, migraines).

FAMILY HISTORY

Please identify if any of the child's biological, "blood" relatives have suffered from the following conditions. Please identify the relationship using "maternal" for mother's side and "paternal" for father's side as it pertains to the child. For example, if mother's brother has diabetes, then next to diabetes write "maternal uncle". If father's sister's child has ADHD, then next to ADHD write "paternal cousin" or "paternal first cousin".

Problem	**Relative Affected**
Medical:	
Heart disease, high blood pressure, stroke ----------→	
Mitral Valve Prolapse ----------→	
Diabetes ----------→	
Thyroid disease ----------→	
Medication allergies ----------→	
Epilepsy (seizures, convulsions) ----------→	
Tourette's Disorder, motor or vocal tics ----------→	
Developmental or cognitive:	
Mental retardation ----------→	
Learning disorders, dyslexia ----------→	
ADHD, attention, hyperactive, impulse control problems ---→	
Educational:	
Severe academic problems ----------→	
Severe school behavior problems ----------→	
Did not finish high school ----------→	
Environmental (including non-blood relative housemates):	
Suffered physical abuse ----------→	
Suffered sexual abuse ----------→	
Suffered emotional abuse ----------→	
Exposure to toxins (e.g. lead, arsenic, asbestos) ----------→	
Behavioral:	
Antisocial behavior (aggressive criminal behavior, assaults)---→	
Legal problems (repeat offenses, arrests) ----------→	
Violent behavior ----------→	
Stealing, lying, cruelty to people or animals, ----------→	
Destruction of property, fire setting ----------→	
Psychiatric:	
Severe Anxiety, OCD, phobias "nerve problems" ----------→	
Severe Depression ----------→	
Manic Depression, Bipolar Disorder ----------→	
Schizophrenia, Schizoaffective, psychotic disorders ----------→	
Suicide attempts or completions (specify which) ----------→	
Admission to psychiatric hospital ----------→	
Substance Abuse:	
Alcohol dependence, "Detox" or DT's ----------→	
DUI, especially repeat offenders ----------→	
Drug abuse, "street" or prescription ----------→	

SOCIAL HISTORY

Parents:

Biological Mother Name _____ Date of Birth _____ Age _____
Occupation_____ How long? _____
Characterize mother's feelings about her childhood and relationship with her parents.

What are mother's future career or educational plans?

Mother figure if different Name _____ Date of Birth _____ Age _____
Occupation_____ How long? _____
Characterize mother's feelings about her childhood and relationship with her parents.

What are mother's future career or educational plans?

Biological Father Name _____ Date of Birth _____ Age _____
Occupation_____ How long? _____
Characterize father's feelings about his childhood and relationship with his parents.

What are father's future career or educational plans?

Father figure if different Name _____ Date of Birth _____ Age _____
Occupation_____ How long? _____
Characterize father's feelings about his childhood and relationship with his parents.

What are father's future career or educational plans?

Parent's Relationship:

Describe current parent's marriage relationship.

If divorced, describe relationship between divorced parents. Include issues related to custody, child support, and visitation.

Please describe types of discipline used in the home. Include privileges, responsibilities, and consequences (punishments) for the child.

Moves:

Please list all family moves since the child's birth. Identify the year of the move.

Child's Issues:

Peers:

Does your child have many friends? ❑ Yes ❑ No
Do you approve of your child's friends? ❑ Yes ❑ No
What concerns you or satisfies you about the friends?

Would you describe your child as a ❑ follower or ❑ leader?

Sexual Issues:

Do you have any concerns about your child's sexual orientation? ❑ Yes ❑ No
Is your child sexually active? ❑ Yes ❑ No ❑ Unsure
If so, does your child use birth control or disease prevention? ❑ Yes ❑ No ❑ Unsure
Comments:

Substance Use:

What do you know or suspect about your child's use of:
Alcohol
Tobacco
Marijuana
Other drugs

SCHOOL INFORMATION

Current or Most Recent School: ❑ Public ❑ Private ❑ Home School (complete for zoned school)

Name _____ County _____ Grade level _____
Address _____ Guidance Counselor Name _____
_____ Primary Teacher Name _____
Phone _____
Fax if known _____

Services:

Has your child repeated a year? Indicate grade and reason why.

Has your child received special education designation or services? Specify type and grade level.
This includes speech, tutoring, reading help as well as Learning Disorder (LD), Emotional Disorder (ED), Behavior Disorder (BD), Educationally Handicapped (EH, EMH, TMH), Other Health Impaired (OHI). Also include advanced placement, gifted programming (SCOPE, Governor's School, etc.)

Does your child otherwise have an IEP separate from above? Is there a "504 Accommodation Plan"?

Has your child been tested for any of the above? If so, what year? Try to provide a copy of the evaluation.

Timeline:

Please fill in the chart below.
For Average Grade use A-F. For O,G,S,N system use A=O, B=G, C=S, D=N.
For Behavior use G=Good, OK=Average, P=Poor.
For Overall Function use your impression on scale 0-5 with 0=unbearably horrible to 5=awesome, fantastic.

Grade	Name of School	Average Grade A-F	Behavior G, OK, P	Overall Function Rate 0-5
Pre K				
Kgrtn				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

ANYTHING ELSE?

Use this space to answer questions you may not have had room for. Please refer to the page and section.
Use this space to say anything else you want.

Thank you for completing this form. We appreciate the time and effort required.

RACSB Child/Adolescent Pre-Intake Summary

Name of Child/ Adolescent: _____ Date: _____

Name of Parent: _____Phone: _____

Referred by (i.e., Self or Name of doctor/provider/social worker): _____

Please check any problems that your child/ adolescent has experienced or demonstrated in the last 1-3 months:

____Mood Swings	____Property Destruction	____Thoughts of Killing
____Depression/Sadness	____Anger	____Self-harm Thoughts
____Anxiety/ Fears	____Social Problems	____Racing Thoughts
____Nervousness	____Withdrawal	____Suicidal Thoughts
____School Avoidance	____Repetitive Behaviors	____Suicide Attempt
____Irritability	____Problems learning	____Seeing Visions
____Temper Outbursts	____Argumentativeness	____Hearing Voices
____Attention Problems	____Stealing	____Sleep Problems
____Hyperactivity	____Lying	____Sexual Problems
____Impulsivity	____Rule-breaking	____Appetite Changes
____Aggressiveness	____Running away	____Alcohol or Drug Use

Please list any medications, who prescribes, and what time they are taken: _____
_____
_____

History of hospitalizations in the last 6 months (e.g., dates, location and reason for hospitalization): _____
_____
_____

History of trauma during your child/adolescent's lifetime (e.g., abuse, neglect, sexual abuse, witnessing domestic or community violence): _____
_____
_____
_____
_____

Recent (within the past year) changes to home situation or family stressors (e.g., births, deaths, divorce or separation, financial stress, moves): _____
_____
_____
_____
_____