

PERSPECTIVES OF TROY, P.C.

CHILD

Dx _____

SCREENING INFORMATION

Please Print Clearly

THIS SHEET MUST BE FILLED IN COMPLETELY

Readmit: Yes No

Date _____ Client's Social Security # _____ Case # _____

Client's Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Cell) _____

Ok to leave messages? Home: yes no Work: yes no Cell: yes no

Birthdate ____/____/____ Age _____ Gender F M Race _____

Adult's Email address (used for marketing purposes only) _____

Name of Parent/Guardian _____ Phone _____

Address _____ City _____ State _____ Zip _____

Emergency Information

In case of emergency, contact:

Name (1) _____ Relationship _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name (2) _____ Relationship _____ Phone _____

Address _____ City _____ State _____ Zip _____

Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

Other Physician _____ Phone _____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place _____ Occupation _____ Hrs _____

Spouse: Place _____ Occupation _____ Hrs _____

Insurance Information

Primary Insurance _____

Contract/ID# _____

Group/Acct# _____

Subscriber _____

Subscriber Social Security # _____

Subscriber Date of Birth _____

Client's relationship to Subscriber

Self Spouse Son/Daughter

Secondary Insurance _____

Contract/ID# _____

Group/Acct# _____

Subscriber _____

Subscriber Social Security # _____

Subscriber Date of Birth _____

Client's relationship to Subscriber

Self Spouse Son/Daughter

Referral Source

How did you hear of our clinic (or from whom)? _____

Address _____ City _____ State _____ Zip _____

Phone _____

Perspectives Counseling Centers

Personal History -Child and Adolescent-

Client's Name _____ Date _____

Gender ___ F ___ M Date of birth _____ Age _____ Grade in school _____

Form completed by ___ Parent ___ Child

Address _____ City _____ State _____ Zip _____

If you need any more space for any of the following questions please use the back of the sheet.

Primary reason(s) for seeking services

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Anger management | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Coping | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Fear/phobias | <input type="checkbox"/> Mental confusion | <input type="checkbox"/> Sexual concerns |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Addictive behaviors | <input type="checkbox"/> Alcohol/drugs | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Self Injury | <input type="checkbox"/> Self Esteem | <input type="checkbox"/> Behavior Problems | |
- Other mental health concerns (specify) _____
- _____

How long have these symptoms been present? _____

What are your goals for the child's therapy? _____

What family involvement would you like to see in the therapy? _____

What areas of your life are being affected by the above?

Social

- Unable to form or maintain friendships
- withdrawal from family and friends (excessive desire to be alone)
- increased conflict with others
- loss of interest in social activities
- phobias

Occupational

- unable to maintain job
- absenteeism
- conflicts with co-workers
- tardiness
- reduced productivity
- disciplinary action for poor performance

Academic

- failing grades
- skipping school
- tardiness
- detention
- reduced productivity at school
- fighting/conflicts with students/teachers

Physical

- decreased energy/fatigue
- difficulty getting out of bed or insomnia
- decreased/increased appetite
- substantial weight loss or gain
- psychosomatic complaints (headaches, stomachaches, etc.)
- frequent illness

Affective Distress

- crying spells
- mood swings
- anger/rage
- disorganized thoughts
- feeling overwhelmed with emotions
- worrying that interferes with the ability to concentrate
- memory problems
- concentration problems

Parental Information

With whom does the child live at this time? _____

Are parent's divorced or separated? No Yes (when?) _____

If Yes, who has legal custody? _____

Were the child's parents ever married? Yes No

Is there any significant information about the parents' relationship or treatment toward the child that might be beneficial in counseling? Yes No If Yes, describe _____

Client's Mother

Name _____ Age _____ Occupation _____ FT PT

Where employed _____ Work phone _____

Mother's education _____

Is the child currently living with the mother? Yes No If No, which of the following?

Step-parent Adoptive parent Foster home Other (specify) _____

Is there anything notable, unusual or stressful about the child's relationship with the mother?

Yes No If Yes, please explain _____

How is the child disciplined by the mother (eg. grounding, spanking)? _____

For what reasons is the child disciplined by the mother? _____

Client's Father

Name _____ Age _____ Occupation _____ FT PT

Where employed _____ Work phone _____

Father's education _____

Is the child currently living with the father? Yes No If No, which of the following?

Step-parent Adoptive parent Foster home Other (specify) _____

Is there anything notable, unusual or stressful about the child's relationship with the father?

Yes No If Yes, please explain _____

How is the child disciplined by the father (eg. grounding, spanking)? _____

For what reasons is the child disciplined by the father? _____

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good

Others living in the household	Relationship (e.g., cousin, foster child)	Quality of relationship with the client
_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good

Comments _____

Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurrences of miscarriages or stillborns? Yes No

If Yes, describe _____

Was the pregnancy with child planned? Yes No Length of pregnancy _____

Mother's age at child's birth _____ Father's age at child's birth _____ Child # _____ of _____ total children.

How many pounds did the mother gain during the pregnancy? _____

While pregnant did the mother smoke? Yes No If Yes, what amount _____

Did the mother use drugs or alcohol? Yes No If Yes, type/amount _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication) Yes No If Yes, describe _____

Length of labor _____ Induced Yes No Caesarean? Yes No

Baby's birth weight _____ Baby's birth length _____

Describe any physical or emotional complications with the delivery _____

Describe any complications for the mother or the baby after the birth _____

Length of hospitalization Mother _____ Baby _____

Infancy/Toddlerhood Check all which apply

- Breast fed Milk allergies Vomiting Diarrhea
- Bottle fed Rashes Colic Constipation
- Not cuddly Cried often Rarely cried Overactive
- Resisted solid food Trouble sleeping Irritable when awakened Lethargic

Developmental History Please note the age at which the following behaviors took place

- Sat alone _____ Dressed self _____
- Took 1st steps _____ Tied shoe laces _____
- Spoke words _____ Rode two-wheeled bike _____
- Spoke sentences _____ Toilet trained _____
- Weaned _____ Dry during day _____
- Fed self _____ Dry during night _____

Compared with others in the family, child's development was slow average fast

Age for following developments (fill in where applicable)

- Began puberty _____ Menstruation _____
- Voice change _____ Convulsions _____
- Breast development _____ Injuries or hospitalizations _____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect)

Any history or being abused by others? No Yes If Yes, what type(s) of abuse?

Emotional Sexual Physical Verbal Other describe _____

What age was the child when he or she was abused? _____

Child's Peer Relationships

- Spontaneous Follower Leader Difficulty making friends
- Makes friends easily Long-time friends Shares easily
- Other (describe) _____

Social Skills: Good Average Poor

Who handles responsibility for your child in the following areas?

- School Mother Father Shared Other (specify) _____
- Health Mother Father Shared Other (specify) _____
- Problem behavior Mother Father Shared Other (specify) _____

Discipline Techniques: _____

Quality of Parents' Marriage: Good Average Poor

Does arguing happen in front of the child? Yes No

Cultural/Ethnic

To which cultural or ethnic group, if any, does your child belong? _____

Is he/she experiencing any problems due to cultural or ethnic issues? Yes No

If Yes, describe _____

Other cultural/ethnic information _____

Spiritual/Religious

How important to you are spiritual matters to your child? Not at all Little Moderate Much

Is he/she affiliated with a spiritual or religious group? Yes No

If Yes, describe _____

Was he/she raised within a spiritual or religious group? Yes No

If Yes, describe _____

Would you like your spiritual/religious beliefs incorporated into your child's counseling? Yes No

If Yes, describe _____

Child's Current Legal Status

Is your child mandated for treatment? Yes No

If yes, explain: _____

Is your child involved in any active cases (traffic, civil, criminal)? Yes No

If Yes, please describe and indicate the court and hearing/trial dates and charges _____

Are you presently on probation or parole? Yes No

If Yes, please describe _____

Child's Past Legal History

Traffic violations Yes No

DWI, DUI, etc. Yes No

Criminal involvement Yes No

Civil involvement Yes No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results
_____	_____	_____	_____
_____	_____	_____	_____

Education

Current school _____ School phone number _____

Type of school Public Private Home schooled _____

Grade _____ Teacher _____ School Counselor _____

In special education or gifted program? No Yes Describe _____

Has child ever been held back in school? Yes No If Yes, describe _____

Which subjects does the child enjoy in school? _____

Which subjects does the child dislike in school? _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? Yes No

If Yes, describe _____

Has the child been tested psychologically? Yes No

If Yes, describe (and bring reports) _____

Feelings about School Work Check the descriptions that specifically relate to your child.

- Anxious Passive Enthusiastic Fearful
- Eager No expression Bored Rebellious
- Other (describe) _____

Approach to School Work

Organized Industrious Responsible Interested
 Self-directed No initiative Refuses Does only what is expected
 Sloppy Disorganized Cooperative Doesn't complete assignments
 Other (describe) _____

Performance in School (Parent's/Guardian's Opinion)

Satisfactory Underachiever Overachiever Other (describe) _____

Work

If the child is involved in a vocational program or works a job, please fill in the following
What is the child's attitude toward work? Poor Average Good Excellent
Current employer _____ Position _____ Hours per week _____
How have the child's grades in school been affected since working? Lower Same Higher

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts)

Activities	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Annual Income: \$ _____ Personal income \$ _____ Household Income

Parents' Work: Father: Full Time Part Time Temp Laid-off Disabled Retired Student
Mother Full Time Part Time Temp Laid-off Disabled Retired Student

Medical/Physical Health Condition (Check any problem areas your child has or has had)

For each illness listed below, choose a single answer that best describes your child's health history:

Condition	Currently	In Past	Never	Condition	Currently	In Past	Never
Anemia				Miscarriage			
Appetite Change				Loss of Consciousness			
Asthma				Memory Loss			
Arthritis				Multiple Sclerosis			
Back Pain				Numbness			
Blood In Stool				Pain (Daily, Longer than 2 weeks)			
Blurred Vision				Palpitations			
Caffeine Use				Paralysis			
Chest Pain				Rheumatic Fever			
Chicken Pox				Seizures			
Chronic Cough				Shortness of Breath			
Colitis or Irritable Bowel				Skin Disease			
Confusion or Disorientation				Sleep Apnea			
Constipation				Sleep Difficulties			
Diabetes				Stroke or TIA			
Diarrhea				Swallowing Difficulty			
Dizziness				Dental Problems			
Emphysema				Thyroid Disease			
Fainting				Tuberculosis			
Glaucoma				Ulcers or Indigestion			
Head Injury				Urination Difficulty			
Headaches (Frequent)				Sexually Transmitted Disease			
Hearing Loss				HIV/AIDS/Weakness			
Heart Disease				Recent Weight Gain			
Hepatitis				Recent Weight Loss			
Malnutrition				Other:			

Do any of these illnesses significantly challenge or limit your child's ability to function at school or at home? If yes, please provide details:

List any other of your child's current health concerns _____

List any recent health or physical changes _____

Does your child have any physical/psychological disabilities? Yes No

Explain _____

Do you feel he/she has made an adjustment to the disability/disorder? Yes No

Does your child need any need for assistive technology in the provision of counseling services?

Yes No Explain: _____

Please list all of your child's current prescription and non-prescription (over-the-counter) medications:

Name of your current medicine	What do you use it for?	When did you begin taking it?	What is the strength of each tablet or capsule?	What dose do you take, and how often?	Name of prescribing physician
Example: "Amoxicillin"	Strep Throat	11/1/2005	1 table = 250 mg.	1 tablet, 3 times a day at meals	Dr. Smith

Please list all medications that your child has taken in the past:

Name of your previous medicine	What did you use it for?	How long did you take it?	When did you stop taking it?	Why was it stopped?	Did the medicine cause any problems?
Example: "Tetracycline"	Acne	6 months	9 months ago	Acne improved	Stomach upset

Please list all nutritional and herbal supplements that your child currently takes: _____

Medication **Allergies:** _____

Describe child's overall compliance with the above medications _____

Primary care physician _____

Phone _____

Hospital of choice _____

Phone _____

Address _____

Most recent examinations

Type of examination	Date of most recent visit	Results
Physical examination	_____	_____
Dental examination	_____	_____
Vision examination	_____	_____
Hearing examination	_____	_____

Immunization record (check immunizations the child/adolescent has received)

	DPT	Polio		
2 months	___	___	15 months	___ MMR (Measles, Mumps, Rubella)
4 months	___	___	24 months	___ HBPV (Hib)
6 months	___	___	Prior to school	___ HepB
18 months	___	___		
4-5 years	___	___		

Physical Family Health History

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Deafness | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Perceptual motor disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glandular problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Heart diseases | <input type="checkbox"/> Spinal Bifida |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> High blood pressure | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease | |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Mental Retardation | |
| <input type="checkbox"/> Cleft lips | <input type="checkbox"/> Migraines | |
| <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Multiple sclerosis | |

Comments regarding Family Health _____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	___ / week	_____	___ No	___ Low	___ Med	___ High
Lunch	___ / week	_____	___ No	___ Low	___ Med	___ High
Dinner	___ / week	_____	___ No	___ Low	___ Med	___ High
Snacks	___ / week	_____	___ No	___ Low	___ Med	___ High

Comments _____

Child's Height _____ Weight _____

Personal (Child's) Psychiatric History of:	Currently	In the Past	Never
ADHD			
Substance Abuse			
Anxiety			
Depression			
Manic Depression (Bipolar)			
Schizophrenia			
Suicide Attempt			
Nervous Breakdown			
Panic Attacks			
Psychiatric Hospitalizations			

List family history of mental illness/substance abuse: Mother = mo father = fa sibling = s grandmother = gm grandfather = gf

Family Psychiatric History of:	Currently	In the Past	Never
ADHD			
Alcohol Abuse			
Anxiety			
Depression			
Drug Abuse			
Manic Depression (Bipolar)			
Schizophrenia			
Suicide Attempt			
Nervous Breakdown			
Panic Attacks			
Psychiatric Hospitalizations			

Do any of these illnesses significantly challenge or limit your child's ability to function at work or at home? If yes, please provide details:

Counseling/Prior Treatment History

Information about child/adolescent (past and present)

	Yes	No	When	Where	Overall experience
Mental health counseling	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____

Behavioral/Emotional

Please check any of the following that are typical for your child:

- | | | |
|--|--------------------------|--------------------------|
| ___ Affectionate | ___ Frustrated easily | ___ Sad |
| ___ Aggressive (___verbal ___physical) | ___ | ___ Gambling |
| ___ Selfish | | |
| ___ Alcohol problems | ___ Generous | ___ Separation anxiety |
| ___ Angry | ___ Hallucinations | ___ Sets fires |
| ___ Anxiety | ___ Head banging | ___ Sexual addiction |
| ___ Attachment to dolls | ___ Heart problems | ___ Sexual acting out |
| ___ Avoids adults | ___ Hopelessness | ___ Shares |
| ___ Bedwetting | ___ Hurts animals | ___ Sick often |
| ___ Blinking, jerking | ___ Imaginary friends | ___ Short attention span |
| ___ Bizarre behavior | ___ Impulsive | ___ Shy, timid |
| ___ Bullies, threatens | ___ Irritable | ___ Sleeping problems |
| ___ Careless, reckless | ___ Lazy | ___ Slow moving |
| ___ Chest pains | ___ Learning problems | ___ Soiling |
| ___ Clumsy | ___ Lies frequently | ___ Speech problems |
| ___ Confident | ___ Listens to reason | ___ Steals |
| ___ Cooperative | ___ Loner | ___ Stomach aches |
| ___ Computer addiction | ___ Low self-esteem | ___ Suicidal threats |
| ___ Defiant | ___ Messy | ___ Suicidal attempts |
| ___ Depression | ___ Moody | ___ Talks back |
| ___ Destructive | ___ Nightmares | ___ Teeth grinding |
| ___ Difficulty speaking | ___ Obedient | ___ Thumb sucking |
| ___ Dizziness | ___ Often sick | ___ Tics or twitching |
| ___ Drug dependence | ___ Oppositional | ___ Unsafe behaviors |
| ___ Eating disorder | ___ Over active | ___ Unusual thinking |
| ___ Enthusiastic | ___ Over weight | ___ Weight loss |
| ___ Excessive masturbation | ___ Panic attacks | ___ Withdrawn |
| ___ Expects failure | ___ Phobias | ___ Worries excessively |
| ___ Fatigue | ___ Poor appetite | ___ Other _____ |
| ___ Fearful | ___ Psychiatric problems | |
| ___ Frequent injuries | ___ Quarrels | |

Please describe any of the above (or other) concerns _____

How are problem behaviors generally handled? _____

Has the child/adolescent experienced death? (friends, family pets, other) ___Yes ___No
 At what age? _____ If Yes, describe the child's/adolescent's reaction _____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)
 ___Yes ___No If Yes, describe _____

Do you suspect your child is using any alcohol or drugs? (including illicit, prescription, over-the-counter or cigarettes) ___ Yes ___ No Explain _____

Any additional information that you believe would assist us in understanding your child/adolescent?

Do you believe the child is suicidal/homicidal at this time? Yes No

If Yes, explain _____

Is your child engaged in any risk taking behaviors? Yes No If yes, describe _____

Signature of person filling out form

Date

For Staff Use

Therapist's comments _____

Therapist's signature _____ Date ___/___/___

Supervisor's comments _____

Physical exam Suggested Not suggested

Supervisor's signature/credentials _____ Date ___/___/___

(Certifies case assignment, level of care and need for exam)

Therapist's response to supervisor's remarks _____

Therapist's signature/credentials _____ Date ___/___/___