Name: _____ Date: _____

KRIST SAMARITAN COUNSELING CENTER
Child/Adolescent Clinical History Form

*If you are filling this out on behalf of the patient, please answer from the patient's perspective.

INTRODUCTORY INFORMATION

Please let us know who referred you: _____

May we contact them to extend a thank you for the referral? (please circle) YES NO

Would you like us to share our findings and recommendations with them after our initial evaluation? (please circle) YES NO

If YES, please provide the contact information for the person who referred you: _____

	Parent/Guardian 1	Parent/Guardian 2
Name		
Address		
Email		
Home Phone		
Cell Phone		
Work Phone		

Person completing this form: _____ Relationship: _____

CHIEF COMPLAINT

What issues are you seeking help for at this time? _____

_____

_____

When did you first notice these issues? _____

What things did you first notice? _____

Was the onset sudden or gradual? _____

Please describe any life event(s) or action(s) that you or others think might have contributed to these sisues (be as detailed as possible). _____

_____

_____

What are your goals for the current treatment/evluation? _____

_____

_____

CURRENT BEHAVIOR

Which of the following are concerns you have about your child? (Please check all that apply.)

	Yes	No
Problems getting along with family		
Problems getting along with peers		
Hard time talking to peers in some situations		
Hard time talking to non-family adults		
Difficulty understanding jokes		
Poor eye contact		
Self-conscious, fear of embarrassment, shy		
Uncomfortable socially		
Fear of social situations		
Sensitive to crowds		
Stubborn		
Distrustful, suspicious, secretive		
Lying, sneaking		
Frequent arguing		
Oppositional/defiant		
Temper tantrums, explosive episodes		
Acting violently		
Fire setting		
Rule breaking		
Property destruction		
Stealing		
Cruelty to animals		
Running away		
Risk taking behavior		
Alcohol abuse		
Other substance abuse		
Abuse perpetrator		
Self-esteem problems		
Immaturity		
Angry, aggressive		

	Yes	No
Irritable		
Self-destructive/self-abusive behaviors		
Suicial talk/thoughts of killing self		
Suicidal behavior; has hurt or cut self		
Depression/depressed mood/sadness		
Tearful crying spells		
Feeling hopeless, helpless, and/or worthless		
Grief/loss		
Lack of energy, fatigue		
Withdrawn		
Lack of motivation		
Not enjoying usual activities		
Difficulty making decisions		
Difficulty planning ahead		
Overwhelmed/stressed		
Feeling guilty		
Moodiness		
Moods change quickly		
Change in personality		
Excessively good/grandiose mood, euphoria		
Excessive energy		
Little sleep but not tired, decreased need for sleep		
Racing thoughts, flight of ideas		
Blackouts		
Hallucinations, delusions		
Strange ideas or behaviors		
Poor awareness of time		
Anxiety		
Panic attacks		
Obsessions or compulsions		
Perfectionism		
Rigid/inflexible		
Repetitive behaviors		
Head banging, rocking		
Skin-picking		
Hair pulling		
Gets frustrated easily		
Abuse victim; trauma history		
Worried		
Fear of bedtime		
Nightmares		
Stuttering		
Involuntary vocalizations		
Resistance to school		

	Yes	No
Learning problems; language problems		
Trouble concentrating; memory problems; disorganization		
Difficulty following directions		
Difficulty getting started on tasks		
Difficulty staying on one task for a long time		
Difficulty with finishing a task; difficulty completing homework		
Distractible, gets easily distracted		
Difficulty with transitions		
Difficulty listening		
Impulsiveness		
Bouts of excessive energy; always in motions; escessively fidgety; hyperactive		
Talkative		
Poor judgment		
Poor handwriting		
Tics/twitching		
Been pregnant		
Had an abortion; partner had an abortion		
Sexual problems		
Dizziness; seizures		
Pain/body complaints		
Sensory issues		
Blank spells; fainting spells		
Bed wetting, soiling		
Breath holding		
Change in sleep habits; difficulty sleeping		
Change in eating habits/appetite; significant weight changes		
Eating problems; overeating; eating too little; eating disorder		
Eats paint, paper, etc.		
Nail biting; thumb sucking		
Toileting problems		
Uncoordinated, clumsy using hands, clumsy walking		
Frequent urinary accidents		

If you have other concerns not listed above, please note them here: _____

_____

_____

If any of the above behaviors were significant issues which have now gone away, please describe: _____

_____

_____

Please note the degree of impairment in the child's:

	None	Mild	Moderate	Marked	Extreme
Family relationships					
School performance					
Friendships/peer relationships					
Hobbies/play activities					
Daily self-care					
Physical health					
Eating habits					
Sleeping habits					

	Normal	Lax	Preoccupied with issues
How would you describe your child's conscience?			

	Not at all	Mildly	Moderately	Extremely
Overall, how concerned are you with your child's behavior over the last few months?				

Please note any important additional information regarding your child's current behaviors: _____

_____

_____

_____

REVIEW OF SYSTEMS

Please look at the list of physical symptoms below and circle any that your child has experienced in the last several days. If s/he has NOT experienced any symptoms in an area, be sure to circle "None of the above" for that area.

Constitutional		
Chronic pain	Loss of appetite	Increase in appetite
Unexplained weight loss	Weight gain	Fatigue/lethargy
Unexplained fever	Hot or cold spells	Night sweats
Sleeping pattern disruption	Malaise (flu-like/vague sick feeling)	
Other:	None of the above	
Eyes		
Eye pain	Eye discharge	Eye redness
Blurred or double vision	History of eye surgery	Sensitivity to light
Scotomas (blind spots)	Retinal hemorrhage (floaters)	Amaurosis fugax (filling like a curtain is pulled over vision)
Other:	None of the above	
Ears, Nose, Throat, and Mouth		
Earache	Tinnitus (ringing in ears)	Decrease hearing or hearing loss
Frequent ear infections	Frequent nose bleeds	Sinus congestion
Runny nose/post-nasal drip	Difficulty swallowing	Frequent sore throat
Prolonged hoarseness	Pain in jaw or tooth	Dry mouth
Other:	None of the above	

Cardiovascular		
Chest pain	Pacemaker	Swollen feet or hands
Palpitations (fast or irregular heartbeat)	Fainting spells	Shortness of breath with exercise
Other:	None of the above	
Respiratory		
Pain with breathing	Chronic cough	Chronic shortness of breath
Chronic wheezing/Asthma	Excessive phlegm	Cough blood
Nocturnal Dyspnea (shortness of breath at night)	Other:	None of the above
Musculoskeletal		
Swelling in joints	Redness of joints	Other joint pains or stiffness
Muscle pain or cramping	Muscle weakness	Muscle stiffness
Decreased range of motion	Back pain or stiffness	History of fractures
Past injury to spine or joints	Other:	None of the above
Gastrointestinal		
Excessive flatulence or belching	Heartburn	Change in appearance of stool
Diarrhea	Difficulty swallowing solids/liquids	Blood in stool
Constipation	Recent loss in appetite	Dark/tarry stool
Persistent nausea/vomiting	Sensitivity to milk products	Loss of bowel control
Abdominal pain	Jaundice (yellow skin)	
Other:	None of the above	
Allergic/Immunologic		
Frequent infections	Hives	Anaphylaxic reaction
Other:	None of the above	
Endocrine		
Severe menopausal symptoms	Cold or heat intolerance	Excessive appetite
Excessive thirst or urination	Excessive sweating	Diabetes
Other:	None of the above	
Hematologic/Lymphatic		
Blood clots	Easy bleeding after surgery or dental work	History of blood transfusion
Excessive bruising or bleeding		Swollen glands (neck, armpits, groin)
Other:	None of the above	
Genitourinary (general)		
Loss of urine control	Painful/burning urination	Blood in urine
Increased frequency of urination	Up more than twice a night to urinate	Urine retention
Frequent urine infection		
Other:	None of the above	
Genitourinary (women)		
Unusual vaginal discharge	Vaginal pain, bleeding, soreness, or dryness	Genital sores
Heavy or irregular periods		No menses (period stopped)
Currently pregnant	Sterility/Infertility	Any other sexual or sex organ concerns
Other:	None of the above	
Genitourinary (men)		
Slow urine stream	Scrotal pain	Lump or mass in the testicles
Abnormal penis discharge	Trouble getting/maintaining erections	Any other sexual or sex organ concerns
Inability to ejaculate/orgasm		

Other:	None of the above	
Neurological		
Paralysis	Fainting spells or blackouts	Dizziness/Vertigo
Drowsiness	Slurred speech	Speech problems (other)
Short term memory trouble	Memory difficulties (loss)	Frequent headaches
Muscle weakness	Numbness/tingling sensations	Neuropathy (numbness in feet)
Tremor in hands/shaking	Muscle spasms or tremors	
Other:	None of the above	
Integumentary (Skin, Breast, and Hair)		
Lesions	Unusual mole	Easy bruising
Increased perspiration	Rashes	Chronic dry skin
Itchy skin or scalp	Hair or nail changes	Hair loss
Breast tenderness	Breast discharge	Breast lump or mass
Other:	None of the above	
Psychiatric		
In-depth review of psychiatric system appears earlier in document	Feeling depressed	Difficulty concentrating
	Phobias/unexplained fears	No pleasure from life anymore
	Anxiety	Insomnia
Excessive moodiness	Stress	Disturbing thoughts
Manic episodes	Confusion	Memory loss
Other:	None of the above	

MENTAL HEALTH TREATMENT/EVALUATION HISTORY

Has your child ever received any of the following therapies privately or in school? (Please check all that apply.)

Treatment	Approx. Dates	Inpatient/ Outpatient?	Provider/Facility name & contact information	Reasons for going	Progress noted
__ Psychiatric treatment					
__ Psychological treatment					
__ Counseling					
__ Group therapy					
__ Family therapy					
__ Behavioral interventions					
__ Neurofeedback					
__ Physical therapy					
__ Occupational therapy					
__ Speech & language therapy					

__ Other:					

Has your child ever had any of the following assessments/evaluations performed privately or in school? (Please check all that apply.) IF APPLICABLE, PLEASE BRING PRIOR REPORT(S) TO YOUR APPOINTMENT.

Evaluation Type	Approx. Dates	Inpatient/ Outpatient?	Provider/Facility name & contact information	Reasons for going	Progress noted
__ Learning/Academic/IQ					
__ Psychiatric					
__ Psychological					
__ Developmental					
__ Physical					
__ Neuropsychological					
__ Occupational					
__ Speech & language					
__ Audiology					
__ Neurological (e.g., MRI, CAT scan, EEG, etc.)					
__ Other:					

Has your child ever been given any of the following diagnoses? (Please check all that apply).

Condition	Approx. Date	At what age was this first diagnosed?	Comments
ADHD/ADD			
Anxiety			
Auditory Processing Disorder			
Autism Spectrum Disorder/Asperger's			
Bipolar or Manic-Depressive Disorder			
Depression			
Developmental Delay			
Hearing Impairment			
Learning Disability			
Nonverbal Learning Disorder (NVLD)			
Obsessive Compulsive Disorder (OCD)			
Oppositional Defiant Disorder (ODD)			
Pervasive Developmental Disorder (PDD)			
Selective Mutism			

Condition	Approx. Date	At what age was this first diagnosed?	Comments
Sensory Processing/Integration Disorder			
Tourette's Disorder			
Visual Impairment			
Other:			
Other:			
Other:			

Please note any important additional information regarding your child's mental health treatment/evaluation history: _____

_____

_____

PSYCHIATRIC MEDICATION HISTORY

	Yes	No
Has your child ever taken any medication for psychiatric treatment?		

If YES, please fill out the table below to the best of your knowledge.

Medication Name	Dose	How long? (months)	End date	Therapeutic effect	Side effects	Reason for stopping

MEDICAL HISTORY

Pediatrician/primary care physician's name: _____

Phone number: _____ Fax number: _____

Address: _____

Email address: _____

Would you like us to contact your child's pediatrician/primary care physician? YES NO

What was the date of your child's last physical exam? _____

Was blood work done? YES NO

	Poor	Fair	Good	Excellent
Your child's current physical condition is:				

Please check off whether your child has ever experienced any of the following and/or complains of any of the following conditions. (Please check all that apply.)

	Yes	No		Yes	No
No problems			Menstrual problems		
			Mononucleosis (mono)		
Aches or pains			Measles		
Adenoidectomy			Mumps		
Anemia			Nausea		
Asthma			Numbness in extremities		
Braces or other orthodontic appliances			Obesity		
Bronchitis			Painful urination		
Chest pain			Palpitations		
Chicken pox			PCOS		
Chronic constipation			Physical trauma		
Cold hands/feet			Pneumonia		
Cold intolerant			Poisoning		
Coma			Rubella		
Concussion			Rubeola		
Deformities			Seizures		
Diabetes			Sinus infections		
Difficulty breathing			Skin problems		
Dizziness			Sleep problems		
Ear infections			Stomach aches		
Ear tubes			Stomach problems		
Encephalitis			Strep throat		
Failure to grow			Thrush		
Flushing			Thyroid problem		
Frequent colds			Tiredness		
Frequent fever			Tonsillectomy		
Frequent headaches			Trouble with hearing		
Gastrointestinal condition			Trouble with vision		
Genetic condition (e.g., PKU, sickle cell)			Vomiting		

	Yes	No		Yes	No
Head injury requiring medical attention			Weakness		
Heart defects			Whooping cough		
Heat intolerant			Movement problems (tics, repetitive movements, etc.)		
Loss of consciousness					
Meningitis			Other:		

Please describe any of the conditions checked above (including age of child when the condition, incident, or illness occurred, and how frequently the complaints occur – where applicable):_____

_____

_____

Please answer the following questions:

	Yes/No	If yes, please describe (including age of child and reasons for procedure, where relevant).
Is your child currently under treatment for any of the conditions noted above?		
Has your child experienced any other injuries not noted above?		
Has your child ever been hospitalized?		
Has your child ever had any surgeries or operations?		
Has your child ever had a neurological evaluation (e.g., exam, MRI, CAT scan, EEG)?		

Please list and describe any other current or past medical diagnoses or conditions: _____

_____

_____

Please list all of your child's current and previous medications that were taken for more than one month (include prescription and over-the-counter):

Name of medication	Dose	Reason for taking	Main effects (if any)	Side effects (if any)	Prescriber

	Yes	No	Not applicable
Does your child follow the medication regimen?			

Please list all of the child's current supplements (e.g., vitamins) or alternative/herbal therapies:

Name of supplement or therapy	Dose	Reason for taking

Does your child have any vision or eye problems? YES NO
If YES, please describe: _____

Does your child wear glasses? YES NO
If YES, for what reason(s): _____

Date of last vision screen: _____ Results of last vision screen: _____

Does your child have any hearing problems? YES NO
If YES, please describe: _____

Does your child wear a hearing aide? YES NO
If YES, for what reason(s): _____

Date of last hearing screen: _____ Results of last hearing screen: _____

Does your child have any known allergies to medications, foods, animals, etc.? YES NO
If yes, please describe: _____

_____

Are your child's immunizations up to date? YES NO

Please note any important additional information regarding your child's physical health and/or medical history: _____

_____

_____

MENSTRUATION AND PREGNANCY HISTORY

N/A (circle if not applicable)

At what age did your child begin menstruation? _____

Which of these best describe your premenstrual symptoms? (Please check all that apply.)

	Yes	No		Yes	No
None of these			Appetite change		
			Bloating		
Dysphoria			Sleep disturbance		
Cramps			Other:		
Moodiness			Other:		

Does your child have a method of contraception? (Please check all that apply.)

	Yes	No		Yes	No
No method of contraception			Barrier (e.g., diaphragm, male/female condom, spermicide)		
Intrauterine (e.g., IUD)			Fertility Awareness-based (e.g., natural family planning)		
Hormonal (e.g., implant, injection, "the pill," patch, hormonal vaginal contraceptive ring)			Permanent (e.g., male/female sterilization, infertility)		
			Other:		

Has your child ever been pregnant? _____ If YES, how many times? _____

Has your child ever given birth? _____ If YES, how many times? _____

Has your child had any miscarriages? _____ If YES, how many times? _____

Has your child had any abortions? _____ If YES, how many times? _____

FAMILY MENTAL HEALTH / SOCIAL HISTORY

Please note if any of your child's family members have experienced and/or been diagnosed with any of the following. (Please check all that apply.)

Condition	Family Member(s)	Maternal or Paternal?
Depression		M P
Bipolar/Manic-Depressive Disorder		M P
Suicide (attempted or completed)		M P
Anxiety		M P
Panic Attacks		M P
Obsessive-Compulsive Disorder (OCD)		M P
Tourette Syndrome/Tic Disorder		M P
Autism Spectrum/Asperger's/PDD		M P
"Absent Minded Professor" stereotype		M P
Developmental Delays/MR/IDD		M P
ADHD/Attention Difficulties		M P

Condition	Family Member(s)	Maternal or Paternal?
Hyperactivity (especially as a child)		M P
Schizophrenia		M P
Psychosis or Thought Problems		M P
Learning Disabilities/Difficulties		M P
Reading Disorder/Dyslexia		M P
Kept back in school		M P
Special education		M P
Speech problems (especially as a child)		M P
Bedwetting/Bowel Movement Withholding		M P
Aggressive or violent behaviors		M P
Erratic temper; moods quickly change		M P
Physical or sexual abuse		M P
Alcohol abuse/dependence		M P
Other substance abuse/dependence		M P
Social difficulties		M P
Problems keeping a job		M P
Legal trouble/problems or police contact		M P
Frequently in trouble as a child/teenager		M P
Outpatient psychotherapy		M P
Inpatient psychiatric treatment		M P
Other:		M P

If any of the above were checked, please briefly describe: _____

_____

_____

Please note any important additional information regarding family mental health and/or social history: _____

_____

_____

FAMILY MEDICAL HISTORY

Please note if any of your child's family members have experienced and/or been diagnosed with any of the following. (Please check all that apply.)

Condition	Family Member(s)	Maternal or Paternal?
Birth defects		M P
Blood problems		M P
Brain disease		M P
Cancer		M P
Diabetes		M P
Eating disorders		M P
Gastrointestinal problems		M P
Hearing problems		M P
Heart rhythm problems		M P
Hospitalizations		M P
Kidney problems		M P
Liver problems		M P
Movement problems (e.g., slowness in walking)		M P
Neurofibromatosis		M P
Neurological disorder/problems		M P
Other heart problems		M P
Seizures		M P
Speech problems (e.g., slowness in talking)		M P
Sudden cardiac death (under 60 years old)		M P
Sudden unexplained death (under 60 years old)		M P
Thyroid disease		M P
Visual problems		M P
Weight-related problems		M P
Other:		M P

If any of the above were checked, please briefly describe: _____

_____

_____

Please note any important information regarding family history: _____

_____

_____

PRENATAL DEVELOPMENT AND BIRTH HISTORY

Please select all that apply to your child's prenatal development:

	Yes	No
The mother had prenatal care while pregnant with the child		
The child was conceived through in vitro fertilization		
The mother received medicines to increase fertility		
The child was a multiple birth		
The mother had previous pregnancies. If so, how many? _____		

Number of ultrasounds during pregnancy: _____

Please describe any abnormal findings: _____

_____

_____

Please check off any of the following complications experienced by the mother while pregnant with the child.

	Yes	No		Yes	No
None of these			Infection(s)		
			Injury		
Anemia			Preeclampsia		
Bleeding			Premature labor		
Chronic illness			RH incompatibility		
Excessive vomiting			Surgery		
German measles			Threatened miscarriage		
High blood pressure			Toxemia		
Other:			Other:		

Please describe any of the complications marked above: _____

_____

_____

Please list any medications prescribed to the mother during pregnancy: _____

_____

_____

Did the mother use any of the following while pregnant? (Please check all that apply.)

	Yes	No		Yes	No
None of these			Recreational drugs		
			Prescription medication(s)		
Caffeine			Medical treatment other than routine prenatal care		
Tobacco					
Alcohol			Other:		

Please describe the items selected above (including types and frequency of usage): _____

_____

_____

If the mother had any dietary restrictions while pregnant, please describe: _____

_____

_____

Parents' age at time of delivery: Mother _____ Father: _____

How long was labor (i.e., how many hours from first contractions to birth)? _____ hours

Was the mother under anesthesia during delivery?

	Yes	No
No		
Local		
Spinal		
General		

Was the child born:

On Time	Early	Late

If early or late, by how many days?
_____

How much did the baby weigh at the time of delivery? _____ pounds _____ ounces

Was the baby normally active? YES NO

What was the baby's APGAR score? 1 minute: _____ 5 minute: _____

Please check off any of the following items that pertained to the child during delivery and post delivery.

	Yes	No		Yes	No
None of these			Induced		
			Jaundiced		
Abnormal color			Natural childbirth		
Baby did not cry right away			Needed a respirator		
Birth defect			Received oxygen		
Breeched			Received phototherapy		
Cesarean			Received transfusions		
Cord wrapped around neck			Seizure		
Difficulty breathing			Use of forceps		
Fetal distress			Other:		

Please describe any additional complications: _____

_____

_____

Where was the baby born? _____ At hospital _____ At home Other: _____

If the baby was born in a hospital, how many days was the baby in the hospital after delivery? _____ days

If the baby was born in a hospital, did mother and baby leave the hospital together? YES NO
If NO, please provide the reason: _____

After birth, did the baby say in:

	Yes	No
N/A		
Well-baby nursery		
Neonatal Intensive Care Unit (NICU)		
Other: _____		

Please describe any medical problems your child had in the first few days/weeks of life: _____

_____

_____

Did either parent have significant problems adjusting after the birth (including if mother had problems with depression)? YES NO

If YES, please describe: _____

_____

_____

Was the child adopted? YES NO

If YES, please answer the following:

How old was the child when placed in the adopted parents' care? _____

Please briefly describe the pre-adoption environment: _____

_____

Please briefly describe the circumstances of the adoption: _____

_____

Please note any important additional information regarding the child's prenatal development or birth history:

_____

_____

_____

DEVELOPMENTAL HISTORY

Please check off any of the following items that describe your child's infancy, toddlerhood, and/or preschool:

	Yes	No		Yes	No
Active baby			Failure to thrive		
Anemia			Fears/phobias		
Asthma			Finicky eating		
Bad foot odor			Growing pains		
Bed wetting			Hyperactivity		
Chronic sniffles			Jaundice		
Constipation			Limp		
Convulsions			Nightmares		
Cradle cap			Not calmed by being held; difficult to comfort		
Defiant					
Diaper rash			Poor muscle control		
Diarrhea			Poor muscle tone		
Did not enjoy cuddling			Poor teeth		
Difficult to soothe			Poor weight gain		
Difficulty chewing			Sensory issues		
Difficulty sleeping			Stiff		
Difficulty sucking			Stomach aches		
Disconnected socially			Tremors		
Eczema or psoriasis			Under responsive		
Excessive tantrums			Very sweaty		
Excessively irritable			Warts		
Excessively restless			Other:		

Was the baby (check all that apply):

	Yes	No		Yes	No
Colicky			Bottle fed		
Breast fed			On a special diet		

If YES to any item above, please describe and specify how long for each: _____

_____

_____

Please describe any other feeding issues (e.g., sensitivities; textures; reflux; resistance; difficulty swallowing; drooling; etc.): _____

_____

_____

Was your child an "easy baby" who did not cry easily and was flexible?

Yes, very much so	Yes, pretty easy	Probably above average	No, pretty difficult	No, extremely difficult

When your child was a baby, how was s/he with other people?

Above average	Very wary of strangers, very upset if held by or left with others	Indifferent to strangers, no reaction if held by or left with others

Was your child an active infant/toddler?

Low energy, usually quiet and inactive	Not very active	About average	Quite active	Extremely restless and active, into everything

As an infant/toddler, how insistent was your child when s/he wanted something?

Not insistent at all	Not very insistent	About average	Somewhat insistent	Very insistent