Kalamazoo Office
5340 Holiday Terrace
Kalamazoo, MI 49009

cfps
Child & Family Psychological Services, P.C.

Portage Office
1662 E. Centre Ave.
Portage, MI 49002

CHILD/ADOLESCENT CONFIDENTIAL HISTORY

Please Print Clearly Today's Date _____

Client's Last Name: _____ First Name: _____ MI: ____

Birthdate: ____/____/____ Age: _____ Race: _____

Address _____

City, State _____ Zip_____

Phone: _____ Other Phone: _____

Please indicate with an * which phone numbers we may NOT leave a message.

Email Address: _____

In case of an emergency, contact:

Name _____ Relationship _____

Phone: _____ Other Phone: _____

PRIMARY INSURANCE

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Address (if different than client): _____

Insurance Company Name: _____ Employer:_____

Subscriber's Contract/ID:_____ Group No: _____

Relationship to Client: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

SECONDARY INSURANCE

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Address (if different than client): _____

Insurance Company Name: _____ Employer:_____

Subscriber's Contract/ID:_____ Group No: _____

Relationship to Client: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

How did you find out about Child & Family Psychological Services?

☐ Family/Friend ☐ Web Search ☐ Google ☐ School ☐ Church/Synagogue

☐ DocASAP ☐ CFPS Website ☐ Social Media ☐ Physician ☐ Insurance Company

☐ Other (please specify) _____

How would you like to receive appointment reminders (Check ONE option only)?

☐ Text message to my cell phone number _____(normal text message rates may apply)

☐ Via email message to the following email address:_____

☐ Via automated telephone message to my home or cell phone number _____

☐ None of the above, I'll remember my appointments on my own

Appointment information is considered "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private and requesting that it be handled as I have noted above.

Signature _____ Date _____

Primary reason(s) for seeking services

☐ Anger management ☐ Anxiety ☐ Coping ☐ Depression

☐ Eating disorder ☐ Fear/phobias ☐ Mental confusion ☐ Sexual concerns

☐ Sleeping problems ☐ Addictive behaviors ☐ Alcohol/drugs ☐ Hyperactivity

☐ Self-Injury ☐ Self Esteem ☐ Impulsivity ☐ Behavior Problems

☐ Distractibility

Other mental health concerns (specify): _____

_____

How long have these symptoms been present? _____

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

_____

What are your child's goals for 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

☐ Phobia

☐ Poor social skills

☐ Attachment problems

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

☐ Homework problems

☐ 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, stomach aches, etc.)

☐ Frequent illness

☐ Bed wetting

Affective Distress

☐ Crying spells

☐ Mood swings

☐ Concentration problems

☐ Disorganized thoughts

☐ Feeling overwhelmed with emotions

Affective Distress Continued

☐ Worrying that interferes with the ability to concentrate

☐ Memory problems

☐ Anger/rage

Behavioral/Emotional

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

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

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

_____

_____

_____

Has the child/adolescent experienced death? (friends, family pets, other) ☐ No ☐ Yes

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.)

☐ No ☐ Yes If Yes, describe_____

Do you suspect your child is using any alcohol or drugs? (including illicit, prescription, over-the-counter or

cigarettes) ☐ No ☐ Yes Explain: _____

_____

How are problem behaviors generally handled?_____

_____

_____

Counseling/Prior Treatment History

	Yes	No	When	Where	Overall experience
Mental health counseling	☐	☐			
Psychiatrist for medication	☐	☐			
Suicidal/Homicidal/Violent thoughts	☐	☐			
Suicidal/Homicidal/Violent attempts	☐	☐			
Drug/Alcohol treatment	☐	☐			
Hospitalizations	☐	☐			
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous, etc.)	☐	☐			

Any immediate family in treatment currently? If yes, whom and where? _____

If yes, whom and where? _____

Parental Information

With whom does the child live at this time? _____

_____

Are parents divorced or separated? ☐ No ☐ Yes (when?) _____

If Yes, who has legal/physical custody? _____

Amount of time spent with each parent: _____

Were the child's parents ever married? ☐ No ☐ Yes

****Bring custody paperwork to first session if parents are divorced**

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? ☐ No ☐ Yes

Is there any significant information about the parents' relationship or treatment toward the child that might be beneficial to know for counseling? ☐ No ☐ Yes 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:

☐ Father ☐ Step-parent ☐ Adoptive parent ☐ Foster home ☐ Other (specify): _____

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

☐ No ☐ Yes If Yes, please explain: _____

_____

How is the child disciplined by the mother (e.g. 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:

☐ Mother ☐ Step-parent ☐ Adoptive parent ☐ Foster home ☐ Other (specify): _____

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

☐ No ☐ Yes 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
_____	_____	☐ F ☐ M	☐ home ☐ away	☐ poor ☐ average ☐ good
_____	_____	☐ F ☐ M	☐ home ☐ away	☐ poor ☐ average ☐ good
_____	_____	☐ F ☐ M	☐ home ☐ away	☐ poor ☐ average ☐ good

Others living in the household	Age	Gender	Relationship (e.g., cousin, foster child)	Quality of relationship with client
_____	_____	☐ F ☐ M	_____	☐ poor ☐ average ☐ good
_____	_____	☐ F ☐ M	_____	☐ poor ☐ average ☐ good
_____	_____	☐ F ☐ M	_____	☐ poor ☐ average ☐ 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? ☐ No ☐ Yes If Yes, what amount: _____

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

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication) ☐ No ☐ Yes 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 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 of 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/she was abused? _____

Any history of child abusing others? ☐ No ☐ Yes If Yes, describe: _____

_____

Is there a history of any important separations, losses, deaths, traumas? _____

_____

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	☐	☐		

Child's Peer Relationships

☐ Spontaneous ☐ Follower ☐ Leader ☐ Difficulty making friends

☐ Makes friends easily ☐ Long-time friends ☐ Shares easily ☐ Bullying/being bullied

☐ Other (describe) _____

Social Skills: ☐ Good ☐ Average ☐ Poor

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? ☐ No ☐ Yes

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? ☐ No ☐ Yes

If Yes, describe: _____

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

If Yes, describe: _____

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

If Yes, describe:_____

Child's Current Legal Status

Is your child mandated for treatment? ☐ No ☐ Yes

If yes, explain: _____

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

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

_____

Are you presently on probation or parole? ☐ No ☐ Yes

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 If Yes, describe: _____

Has child ever been held back in school? ☐ No ☐ Yes 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? ☐ No ☐ Yes

If Yes, describe: _____

Has the child been tested psychologically? ☐ No ☐ Yes

If Yes, describe (and bring reports): _____

Current IEP/504 Plan in place at school? ☐ Yes ☐ No

Literacy Level (if known): ☐ Limited (0-275) ☐ Minimal (276 – 325) ☐ High (326 and higher)

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 ☐ Does not complete assignments

☐ Other (describe): _____

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

☐ Satisfactory ☐ Underachiever ☐ Overachiever ☐ Other (Describe)_____

Would you like to have the therapist have communication with the school? ☐ Yes ☐ No

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?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Media/Electronics Use:

☐ Cellphone ☐ Texting ☐ Computer ☐ Facebook ☐ Video Games

☐ Other (Describe): _____

Number of Hours/Day: _____

Do you have conflicts regarding this? (Describe) _____

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

Parents' Work:

Father: ☐ Full Time ☐ Part Time ☐ Temp ☐ Unemployed ☐ Stay-at-Home ☐ Disabled ☐ Retired ☐ Student

Mother: ☐ Full Time ☐ Part Time ☐ Temp ☐ Unemployed ☐ Stay-at-Home ☐ 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			

Condition	Currently	In Past	Never	Condition	Currently	In Past	Never
Diarrhea				Difficulty Swallowing			
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:			

Any other medical conditions that the therapist should be aware of? _____

_____

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: _____

_____

Please list all of your child's <u>current</u> 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	11/1/2017	1 tablet = 250 mg.	1 tablet, 3 times a day at meals	Dr. Smith

Please list all psychiatric medications that your child has taken <u>in the past</u>:

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?	Was the medication effective?
Example: "Lexapro"	Anxiety	6 months	9 months ago	Improved condition	Yes/ No

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

_____

Medication Allergies: _____

Does your child take psychiatric medication? If yes, which type? _____

Who prescribes these medications? ☐ Primary Care Physician ☐ Psychiatrist

Describe child's overall compliance with the above medications: _____

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:		

Physical Activity Level: ☐ Low ☐ Medium ☐ High

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

☐ Allergies	☐ Deafness	☐ Muscular Dystrophy
☐ Anemia	☐ Diabetes	☐ Perceptual motor disorder
☐ Asthma	☐ Glandular problems	☐ Seizures
☐ Bleeding tendency	☐ Heart diseases	☐ Spina Bifida
☐ Blindness	☐ High blood pressure	
☐ Cancer	☐ Kidney disease	
☐ Cerebral Palsy	☐ Mental Retardation	
☐ Cleft lips	☐ Migraines	
☐ Cleft palate	☐ Multiple sclerosis	

Comments regarding Family Health: _____

_____

Child's Height: _____ Weight: _____

Self-Care

Nutrition:

How many consistent meals is s/he you eating/day? _____

Quantity consumed at meals: ☐ Low ☐ Medium ☐ High

Explain: _____

Quality of food eaten: ☐ Low ☐ Medium ☐ High

Explain: _____

Is there anything notable about your child's diet, appetite (gluten free, etc)? _____

Any foods avoided or does s/he only eat certain foods? _____

Does your child eat non-edible items? _____

Sleep:

How many hours of sleep does your child receive in a typical night? _____ Hours

Any problems: ☐ Falling asleep ☐ Staying asleep

How many hours does he/she need to feel rested? _ Hours

Exercise:

Does your child receive regular exercise? Explain type: _____

How often _____/week/month

How long does s/he exercise? _____min/hours

Disabilities:

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 have any need for assistive technology in the provision of counseling services? ☐ No ☐ Yes

Explain: _____

List <u>Family</u> 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			
Drug Abuse			
Depression			
Anxiety			
Manic Depression (Bipolar)			
Schizophrenia			
Suicide Attempt			
Nervous Breakdown			
Panic Attacks			
Psychiatric Hospitalizations			

List <u>Child's</u> history of mental illness/substance abuse:

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			

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:

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

Substance Use History

DRUG	Never Used	Method	Age 1st Use	Age Last use	Onset of heavy use	# Days used in the last 30 days	Use in the past 48 hours	Used As a Prescription	Last Use	Amount used Dly	Amount used Wkly	Drug of choice
Alcohol												
Heroin												
Other Opiates/Painkillers												
Barbiturates/ Sedatives/Hypnotics												
Other Sedatives												
Tranquilizers												
Methamphetamines/ Stimulants												
Cocaine												
Crack												
Hallucinogens/PCP												
Cannabis												
Inhalants												
Antidepressants												

Over-the-Counter												
Nicotine												
Caffeine												
Steroids												
Methadone/ Suboxone												
Benzodiazepine												
Other												

Substance(s) in order of preference

1. _____ 3. _____

2. _____ 4. _____

Describe when and where your child typically uses substances: _____

_____

Describe any changes in his/her use patterns: _____

_____

Describe how your child's use has affected your family or friends: _____

_____

Reason(s) for use

☐ Addicted ☐ Build confidence ☐ Escape ☐ Self-medication

☐ Socialization ☐ Taste ☐ Other (specify): _____

How do you believe substance use affects your child's life? _____

Who or what has helped him/her in stopping or limiting use? _____

Substance Use continued:

Has your child's use of alcohol or drugs interfered with his/her obligations at work? ☐ Yes ☐ No

Has your child's use of alcohol or drugs interfered with his/her obligations at school? ☐ Yes ☐ No

Has your child's use of alcohol or drugs interfered with his/her obligations at home? ☐ Yes ☐ No

Has your child's used alcohol or drugs while driving a car or truck? ☐ Yes ☐ No

Has your child used alcohol or drugs while operating machinery? ☐ Yes ☐ No

Has your child ever been arrested as a result of drinking or using drugs? ☐ Yes ☐ No

Has your child continued to use alcohol or drugs despite having problems caused by the effects of the substance? ☐ Yes ☐ No

Has your child ever used more alcohol or drugs in order to achieve the desired effect? ☐ Yes ☐ No

Has there become a markedly diminished effect with the continued use of the same amount of the substance? ☐ Yes ☐ No

Has your child ever needed to take a drink or use a drug in the morning in order to relieve a hangover? ☐ Yes ☐ No

Has your child ever used substances in larger amounts or over a longer period of time than was initially intended? ☐ Yes ☐ No

Has your child attempted to cut down or control the amount of drinking or drug use without success? ☐ Yes ☐ No

Has your child spent a great amount of time in activities necessary to obtain the alcohol or drugs? ☐ Yes ☐ No

Have important social, occupational, or recreational activities been given up or reduced because of his/her use of alcohol or drugs? ☐ Yes ☐ No

Has your child continued to use alcohol or drugs despite knowing that physical, psychological, or legal problems are likely to occur? ☐ Yes ☐ No

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

If Yes, explain: _____

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

If yes, explain: _____

Is your child engaged in any risk-taking behaviors? ☐ No ☐ Yes

If Yes, describe: _____

_____

_____ _____

Signature of person filling out form Date

For Staff Use

Therapist's comments: _____

_____

_____

_____

_____

Therapist's signature/credentials: _____ Date: __/____/_____

Medical Staff's Comments: _____

_____

_____

Physical exam: ☐ Suggested ☐ Not suggested

Medical Staff Signature & Credentials*: _____ Date: _____/_____/__

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

*= The Medical Director's signature on the assessment form signifies his review of the information contained in this screening form.

Therapist's response to medical staff's remarks: _____

_____

Therapist's signature/credentials: _____ Date: __/____/_____