1. Who is referring the child or adolescent listed below for services (put "self" if you are making the referral)?
2. What is their concern?
3. What is your primary concern?
4. What is the school's primary concern?
5. When did you first become aware of concerns?

Name of Child or Adolescent	First:	Middle:	Last:
Street Address:			
City:		State:	
Phone #		Zip Code:	
Date of Birth:		Race:	
Religion:		Language Spoke in Home:	
Cultural Preferences:		Preferred Language:	
Est. Height:	Est. Weight:		

CUSTODY STATUS

Is there a **court-issued custody agreement**? Yes No ● ***if you have a court issued custody agreement, please attach a copy***
If "Yes" to above, who has <u>legal custody or guardianship</u> of the child?
<u>Are the child's parents married and living together</u>? Yes No ● <u>Are the child's parents A) separated B)divorced or C) never m</u>arried? A B C If "yes", describe the custody arrangements and who has medical custody rights:

FAMILY INFORMATION

FATHER:			
Name		Marital Status	
Address:			
Home Phone ( ) -		Work Phone ( ) -	
MOTHER:			
Name		Marital Status	
Address			
Home Phone ( ) -		Work Phone ( ) -	
STEPMOTHER (if applicable):			
Name		Phone ( ) -	
STEPFATHER (if applicable):			
Name		Phone ( ) -	

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PATIENT INFORMATION

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FAMILY INFORMATION (continued)

List on this page the names of all persons who are currently living in the home with the identified client.

NAME	RELATIONSHIP TO IDENTIFIED CLIENT	AGE

DEVELOPMENTAL INFORMATION

Length of pregnancy:		Birth weight:	
Planned or unplanned pregnancy?			
Was the pregnancy complicated or involved with drugs or alcohol?			
Nature of delivery	Natural	Cesarean	Breech
Condition of child at time of birth:			
If child was adopted, from where?			
Please give age the child or adolescent reached the following developmental milestones:			
Crawled:	Walked:	Talked:	Toilet Trained:

EDUCATIONAL HISTORY

Where is the identified client attending school now?	
What School District?	What grade?
If the child or adolescent is not enrolled, name the last school attended, grade achieved, and date withdrawn:	
Have any grades been repeated?	
Has the child been identified for special education, learning support, emotional support or autism support? Please state year these services started.	

EDUCATIONAL HISTORY (continued)

Does the identified client have an Individualized Educational Plan (IEP)? Yes No
If "yes", describe:

If "yes", are you able to provide a copy of the IEP? Yes No

Has the child or adolescent ever been suspended or expelled from school? Yes No
If "yes", describe:

MEDICAL AND PSYCHIATRIC HISTORY

Family Physician:	Practice Name:

Approximate Date of last Physical Health Exam:

Name of Pharmacy Used:		Pharmacy Telephone:	

INPATIENT HOSPITALIZATION: If the identified client has ever been **hospitalized** please explain when and for what reason:

HOSPITAL NAME	DATES	REASON	DIAGNOSIS

OUTPATIENT TREATMENT: Provide an overview of all prior or current outpatient behavioral health providers:

MENTAL HEALTH PROVIDER	PRACTICE NAME	DATES SEEN

Medications the identified client has been on in the past for mood, anxiety or behavior:

List all medication(s) the child or adolescent is taking now, including medications for any psychiatric or medical issues. Also include any over-the-counter medications/dietary supplements.

MEDICATION NAME	DOSE (Typically in milligrams)	WHEN IS MEDICATION GIVEN

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MEDICAL AND PSYCHIATRIC HISTORY (continued)

Has the identified client ever had problems with aggression? Yes ● No
If so, describe:

Description of any prior Legal Issues:

Has the identified child ever been exposed to abuse (either directly or witnessed abuse)? Yes No

If "yes", please describe whether it was physical, emotional or sexual abuse, and whether the child or adolescent was the subject of the abuse or exposed to it:

MEDICAL CONDITIONS: Please check if any of the following pertain to your child and explain (use back of page if necessary).

	Heart Disease		Orthodontia
	Lung Disease		Skin Disease
	Liver Disease		Irregular Sleep Patterns
	Jaundice		Visual problems
	Seizures		Bowel or Elimination problems
	Fainting		Concussions
	Asthma		Nervous disorders
	Dietary problems		Neurological testing
	Hearing problems		High Fevers
	Urinary problems		Injuries or Broken Bones
	Nausea or vomiting		Accident prone
	Tonsillectomy		Activity limitations
	Pregnancy		Speech problems
	Abortion		Drug or alcohol abuse
	Miscarriage		Diarrhea (frequently)
	Menstrual problems		Diabetes
	Prior Surgical Procedures, if so list:		

List any allergic reactions to medication:

List any other allergies that the identified child may have and how it is treated:

Does the child have an Advanced Directive (either Medical or Mental Health)? YES / NO (circle one)

FAMILY MEDICAL AND PSYCHIATRIC HISTORY

Please check which, if any, of the following conditions/problems apply to the identified client's blood relatives. If other significant medical/psychiatric problems are present among blood relatives, please list those in the space provided below.

	Child's Mother	Child's Father	Child's Brother(s)	Child's Sister(s)	Child's Grandparent(s)
Childhood oppositional/defiant					
Problems with aggression					
Attentional problems					
Learning disabilities					
Failed high school;					
Intellectual or developmental disability					
Psychosis/schizophrenia					
Depression (greater than 2 weeks)					
Anxiety or adjustment disorder					
Panic disorder					
Other mental disorder (describe below)					
Tic disorder or Tourette's					
Alcohol Abuse					
Substance Abuse					
Antisocial behavior (assault/thefts)					
Arrests/incarcerations					
Physical abuse (victim)					
Physical abuse (perpetrator)					
Sexual abuse (victim)					
Sexual abuse (perpetrator)					

Name of person completing this form:

Relationship to child:

By signing below, I certify that all the foregoing information is true and complete.

Signature **Date**

PATIENT INFORMATION

CHILD & ADOLESCENT PARTIAL HOSPITALIZATION QUESTIONNAIRE