NORTHWEST HEALTH SERVICES

Northwest Behavioral Health Services
Your Child's Health History
For children ages 17 and under

Please fill out this form about your child's health. It will help the counselor understand your child's treatment needs. If you need help, your child's therapist will review the form with you at your first visit.

Child's name:		Date:
Child's Date of Birth:	Child's age:	Your Name:
Your relationship to the Child:		

Do you have legal custody of this child? ☐ Yes ☐ No If not, who has custody?_____

If the parents are divorced or separated what is the current visitation arrangement?_____
_____

Is child currently in foster care? ☐ Yes ☐ No Has child ever been in foster care or state custody? ☐ Yes ☐ No

If yes, when and for how long?_____

Your Child's Visit Today

Describe the problems that brought you here today: _____
_____

What would you like to see happen for your child through this counseling/psychiatry session?
_____
_____

Family History

Relationship	Name	Lives with Child?	Age
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Other Relatives			

Client Name_____ Date of Birth_____

☐ Parents legally married or living together
☐ Parents are temporarily separated
☐ Parents divorced or permanently separated

☐ Mother remarried: Number of times_____
☐ Father remarried Number of times _____

Symptoms

Please check all of the behaviors and symptoms that you consider problematic:

☐ Nervous habits	☐ Bangs head	☐ Seems insecure	☐ Curfew violations
☐ Frequent headaches	☐ Grinds teeth	☐ Sad or depressed	☐ Manipulative behavior
☐ Frequent stomach aches	☐ Nightmares	☐ Worries a lot	☐ Toileting problems
☐ Trouble sleeping	☐ Seems angry	☐ Cries a lot	☐ Visual hallucinations
☐ Lacks guilt or remorse	☐ Hurts animals	☐ Alcohol/drug use	☐ Homicidal thoughts
☐ Trouble making/keeping friends	☐ Sets fires	☐ Ignores rules	☐ Peer/sibling conflict
☐ Little interest in activities or friends	☐ Steals	☐ Defies authority	☐ Destroys property
☐ Disrespectful/ argumentative	☐ Lies a lot	☐ Hyperactivity	☐ Running away
☐ Fails to complete schoolwork	☐ Sexually active	☐ Boredom	☐ Swearing
☐ Acts before thinking	☐ Imaginary friends	☐ Thoughts of death	☐ In own world
☐ Separation problems	☐ Too serious	☐ Low self-worth/ esteem	☐ Breaking rules
☐ Unable to sit still	☐ Fights a lot	☐ Underactive	☐ Gambling
☐ Overactive	☐ Clowns around a lot	☐ Sucks thumb	☐ Afraid or fearful of_____
	☐ Acts spoiled	☐ Accident-prone	☐ Impulsive
	☐ Temper tantrums	☐ Binge/purge	
	☐ Change in appetite	☐ Isolates themselves	
	☐ Change in weight		

Please explain the items you have checked _____
_____
_____

If there are other behaviors that are not listed that apply to your child, please list:
_____
_____

Have you, your partner or other adults in the home had problems that may have affected your child? (For example: drinking, drugs, verbal or physical conflict, suicide/attempted suicide, incarceration?) ☐ Yes ☐ No If yes, please explain: _____
_____

Please check if you child has experienced any of the following types of trauma or loss:

☐ Emotional abuse
☐ Sexual abuse
☐ Physical abuse
☐ Parent substance abuse
☐ Recent school changes
☐ Neglect
☐ Violence in the home
☐ Crime victim
☐ Parent illness
☐ Placed a child for adoption
☐ Lived in a foster home
☐ Multiple family moves
☐ Homelessness
☐ Loss of a loved one
☐ Financial problems

Were you separated from your child at any time? ☐ Yes ☐ No If yes, please explain: _____
_____

Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant with this child?
☐ Yes ☐ No ☐ Known ☐ Suspected ☐ Unknown
If yes, please describe the substances used, quantity and the frequency:_____
_____

Did your child have any developmental delays in early childhood (crawling, walking, talking, toileting, etc?):
☐ Yes ☐ No _____
_____

Medical Information

When was your child's last well child exam: _____
Who is your child's Doctor?_____ Phone Number_____
Address: _____

Were there any medical problems during the pregnancy or birth of your child? ☐ Yes ☐ No If yes, please describe:
_____
_____
Has your child been diagnosis with any medical conditions or have any health concerns (serious illnesses, injuries, surgeries or inpatient in the hospital): ☐ Yes No
_____
_____

Current Prescription Medications: ☐ None

Medication	Dosage/ML	How often are you taking?	Reason for Taking?	Prescribed By

Current over the Counter Medications: ☐ None

Medication	Dosage/ML	How often are you taking?	Reason for Taking?	Prescribed By

Your Child's Mental Health History

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (mental health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/Support Groups			

School/Education

Name of School Attending_____ Current grade _____

This year's school grades: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Past year's grades: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

This year's school behavior: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

This year's school grades: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Learning disabilities: ☐ Reading ☐ Math ☐ Writing ☐ Compression ☐ Other _____

Has your child had any of the following difficulties at school?

☐ Suspension ☐ Incomplete homework ☐ Referrals or detentions

☐ Poor Grades ☐ Teasing or picked on ☐ Attendance problems

☐ Gang influence ☐ Bad attitude towards school ☐ Change in performance

Interpersonal/social/cultural

Please check your child's interest:

☐ Watching TV	☐ Collecting things	☐ Baby-sitting
☐ Being with friends	☐ Sewing	☐ Playing with action figures
☐ Playing video games	☐ Drawing	☐ Playing with dolls
☐ Listening to music	☐ Reading	☐ Social Media
☐ Talking on phone	☐ Singing	☐ Hiking
☐ Playing sports	☐ Dancing	☐ Fishing
☐ Riding bikes	☐ Skating	☐ _____
☐ Roller blading	☐ Writing	☐ _____
☐ Building things	☐ Participating in clubs	☐ _____
☐ Imaginary playing	☐ Crafting	

Are there any actives or interests your child no longer enjoys? ☐ Yes ☐ No If yes, please explain: _____

_____

Please describe your child's social support network, check all that apply:

☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-Workers ☐ Support/self-help Group

☐ Community Groups ☐ Religious/Spiritual Center (Which one?) _____

Is your child experiencing any difficulties due to cultural, ethnic, or spiritual issues? ☐ Yes ☐ No If yes, please describe: _____

_____

How important are spiritual matters to your child? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very much

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

Please describe your child's strengths, skills and talents: _____

_____

Legal

Has your child ever been in trouble with the law? ☐ Yes ☐ No Juvenile Office: ☐ Yes ☐ No

Has your child ever been on probation? ☐ Yes ☐ No If yes, when and what did they do?_____

_____

Substance Use History

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines (Meth)								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

Parent/ Guardian Signature:_____ Date:_____

Relationship to patient_____

Reviewed by:

*Therapist/Provider Signature*_____ *Credentials*_____ *Date*_____