

Child's name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Grade: \_\_\_\_\_ Date: \_\_\_\_\_ 1

### Patient Symptom Checklist

What are the problems that caused you to seek help at Excel for the child?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have you had these problems with the child? \_\_\_\_\_

### MENTAL HEALTH TREATMENT HISTORY

OUTPATIENT/INPATIENT OR RESIDENTIAL CARE	DATES

CURRENT PSYCHIATRIST \_\_\_\_\_ TELEPHONE# \_\_\_\_\_

CURRENT THERAPIST \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

### PAST PSYCHIATRIC MEDICATION HISTORY

MEDICATION	PRESCRIBER	DATES	REASON FOR CHANGE/SIDE EFFECTS

### FAMILY MEMBERS MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT HISTORY

RELATIONSHIP	DIAGNOSIS	HOSPITALIZATIONS	MEDICATIONS

Patient raised by \_\_\_\_\_

Patient currently living with \_\_\_\_\_

Others in the home \_\_\_\_\_

Adopted: Yes \_\_\_ No \_\_\_ Age of adoption \_\_\_\_\_ Does child know? \_\_\_\_\_

Circumstances of adoption \_\_\_\_\_

Parents separated \_\_\_\_\_ Divorced \_\_\_\_\_ Age of child at separation \_\_\_\_\_

Custody arrangements \_\_\_\_\_

Child's name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Grade: \_\_\_\_\_ Date: \_\_\_\_\_ 2

Religious History: Child's religion \_\_\_\_\_ Recent changes in religious beliefs? If so, explain \_\_\_\_\_

Any religious beliefs that may affect treatment? \_\_\_\_\_

**Legal History**

Tickets/Citations/Arrests	Dates	Reason

Probation: Yes \_\_\_\_\_ No \_\_\_\_\_ Any special conditions \_\_\_\_\_

Probation Officer: Name \_\_\_\_\_ Tel # \_\_\_\_\_

Court Dates Pending: Date \_\_\_\_\_ Reason \_\_\_\_\_

Depressive Symptoms	Yes	No	Comments /additional thoughts
Depressed or irritable mood most of the day			
Severe decreased interest in pleasurable activities			
Trouble falling asleep, staying asleep, or increased sleep			
Noticeable restlessness or agitation			
Change in usual eating pattern; Less _____ More _____			
Change in weight; Loss _____ Gain _____			
Period of time _____			
Noticeable slow movements			
Expresses Feelings of worthlessness or excessive guilt daily			
Decreased concentration or increased indecisiveness daily			
Recurring thoughts of death or suicide			
Talks about dying or hurting him/herself			
Cutting on self			
<b>Previous suicide attempt?</b>			
Anxiety Symptoms	Yes	No	Comments /additional thoughts
Seems restless, edgy, keyed up			
Separation anxiety, school phobia			
Fear of strangers or new situations			
Obsessions/compulsions			
Persistent nightmares or flashbacks			
Physical complaints			
Refusal or reluctance to go somewhere due to fears			
Excessive fears about being alone			
Child clings to you in public			
Child refuses to go to sleep without you near			
Child throws tantrums to keep you from leaving him/her			

<b>Mood Disorder Symptoms</b>	<b>Yes</b>	<b>No</b>	<b>Comments/Additional thoughts</b>
Complains of being bored			
Complains of a lot of ideas at one time			
Has periods of excessive, rapid speech			
Displays rapid, abrupt mood swings			
Displays periods of hyperactivity			
Has irritable mood states			
Has excessively silly, giddy mood states			
Has exaggerated ideas about self or abilities			
Explosive temper tantrums or rages			
Has destroyed property intentionally			
Curses viciously in anger			
Has physically assaulted another person			
Is fascinated with blood and gore			

Educational History: Special Education; Yes \_\_\_\_\_ No \_\_\_\_\_ Learning Disability \_\_\_\_\_  
 Suspensions: Yes \_\_\_\_\_ No \_\_\_\_\_ Reason \_\_\_\_\_  
 Alternative School Placement: Yes \_\_\_\_\_ No \_\_\_\_\_ Dates \_\_\_\_\_  
 Reason \_\_\_\_\_

<b>Other Issues</b>	<b>Yes</b>	<b>No</b>	<b>Comments/ Additional thoughts</b>
Bedwetting, soiling self			
Sexualized behaviors or sexually bizarre drawings			
Sexually promiscuous, seductive or provocative dress/behavior			
Unusual preoccupation with sexual acts or language			
Sexual acting out play with other children or animals			
Internet usage excessive; My Space, etc			
Reports hearing voices or seeing things			
Bizarre thoughts or behaviors			

<b>Substance Use</b>	<b>Age at first Use</b>	<b>Date of last Use</b>	<b>Frequency: Daily, Weekly, Monthly, Occasional</b>	<b>Amount Used</b>
Drinks alcohol				
Smokes marijuana				
Use amphetamines (speed, ice, crank, etc...)				
Uses cocaine or crack				
Uses inhalants (sniffs glue, paint, air freshener, gasoline, markers, etc...)				
Uses ecstasy				
Uses hallucinogens (LSD, mushrooms, heroin, etc...)				
Uses sedatives (Valium, Xanax, Ativan, etc...)				
Uses painkillers (Vicodin, Oxycontin, Soma, hydrocodone, etc...)				
Uses PCP				
Abuses prescription drugs If yes, what?				
Uses tobacco If yes, what form?				

**ABUSE HISTORY**

TYPE	Child's Age	Abused By	CPS Report Made
Emotional			
Neglect			
Physical			
Sexual			
Domestic Violence			

**DEVELOPMENTAL ISSUES**

Normal pregnancy and delivery? \_\_\_\_\_

Difficulties at birth \_\_\_\_\_

Birth weight \_\_\_\_\_

Able to soothe as an infant \_\_\_\_\_

Sleeping all night at age \_\_\_\_\_

Crawled at age \_\_\_\_\_

Walked at age \_\_\_\_\_

Talked at age \_\_\_\_\_

Appeared to have appropriate social skills for age \_\_\_\_\_

**Special Family Issues That May be Affecting Your Child** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Any other information you think is important for us to know** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_