7700 Cat Hollow Dr., Ste. 206
Round Rock, Texas 78681
www.greatoakscounselingcenter.com

(512) 807-8457 Phone
(512) 501-2259 Fax

ADOLESCENT BEHAVIORAL HEALTH HISTORY

Child/Teen's Name: _____School: _____
DOB: _____Grade: _____Age: _____
Primary Contact Number: _____Home phone: _____
Mom cell: _____ Dad cell:_____Adolescent cell: _____
Parent(s)'/Caregiver Name(s): _____
Email: _____Other Phone: _____
Other Email: _____
Permission to contact and leave a message at all of the above? Yes____ No____
*If no, please circle ones we may contact you at and leave messages.

Please indicate any other professionals currently involved with the child/family:
Primary Care Physician: _____ Phone: _____
Therapist/Counselor: _____Phone: _____
Psychiatrist: _____Phone: _____
Current Medications:
_____
How did you hear about this practice?
_____

What are some of your child's strengths?
_____
_____
_____
_____

What are your current concerns?
_____
_____
_____
_____
_____
_____
_____

How has the family attempted to deal with these concerns?

_____
_____
_____

What do you hope to learn or accomplish as a result of this counseling experience?

_____
_____
_____
_____

SOCIAL/BEHAVIORAL/FAMILY HISTORY

Who lives in the home with this child/teen? Please list names of all people who reside in the home and rate the quality of their relationship with the child/teen (1 = very poor, 2 = poor, 3 = average, 4 = good, 5 = excellent).

List people in home:	Age	Grade/ Level of Education	Relationship to child/teen	Rating (1-5)	Comment

Who is the child's legal guardian (s)?

_____

Are the parents divorced? Yes No

If yes, what are the custodial arrangements?

_____

What are the strengths of this family:_____
_____
_____

What are the struggles of this family:_____
_____
_____

What types of major changes or stressful events has the child or family experienced?

Event(s)	Date	Details

What does your child typically do to cope with stress?

_____
_____
_____

When your child is having behavioral/emotional difficulties, what do you see? Please give examples: _____
_____
_____
_____

Briefly describe any previous therapy experiences (when, how long, what for):

_____
_____
_____
_____

MEDICAL HISTORY

How old were the biological parents when the child/teen was born? ____Mother ____ Father
How was the mother's overall health during the pregnancy? _____
Did the mother experience any medical problems/complications during the pregnancy? No Yes
If yes, please explain:_____
_____

Please indicate any substance by the mother during her pregnancy (which substance, frequency):

_____

At how many weeks gestation was the child/teen born? _____ weeks.
The delivery was (please circle): Typical/Vaginal Breech Caesarian
Forceps /vacuum Induced

Birth weight: _____ pounds, _____ ounces
Any complications during or following the child's birth: Yes No
Comments:_____
_____
_____

Were there any feeding or sleeping problems during infancy? Yes No

Comments:_____
_____
_____

What was the overall difficulty level of caring for him or her as an infant?
___ Very easy ___ Easy ___ Average ___ Difficult ___ Very difficult
As an infant and toddler, how did your child/teen deal with changes in routines/plans/caregivers?
____ Adjusted to change easily ____ Cried
____ Needed some soothing ____ Clingy
____ Actively resisted change ____ Had tantrums
How would you rate the activity level and sociability of this child/teen as an infant or toddler?
____ Much more active than peers ____ Extremely social
____A bit more active than peers ____ Quite social
____About as active as peers ____ Average – sometimes social/sometimes not
____A little less active than peers ____ Somewhat shy/reserved
____ Much less active than peers ____ Fearful of others

Have you or anyone else ever had concerns about this child/teen's early development?Yes No
Comments:_____
_____
_____

DEVELOPMENTAL MILESTONES

Task	Early	Average	Delayed/when
Sitting up without support (avg = 4-7 months)			
Crawling (avg = 6-10 months)			
Walking unassisted (avg = 9-12 months)			
Speaking single words (avg 12-16 months)			
Speaking 2-3 word sentences (avg = 18-24 months)			
Potty Trained (avg = 30-36 months)			

Comments:_____
_____
_____

Date of your child/teen's last physical: _____ Any concerns: _____
_____
How would you describe your child's overall health?
____ Very good _____ Good _____ Fair ____ Poor _____ Very poor

Does he or she have vision or hearing problems? Wear glasses/contacts? Use a device to assist with hearing? No Yes
If yes, please explain:
_____
_____
What time does your child/teen usually go to sleep at night? _____

What time does he or she usually wake up? _____
Describe anything unusual about your child/teen's sleep pattern:

_____

_____

How would describe your child/teen's current eating pattern?
___ Eats very little ___ Eats an average amount ___ Overeats ___ Eats sporadically
___ Recent changes in eating pattern (please describe):
Comments:_____

_____

_____

Any significant illnesses, injuries, hospitalizations, surgeries, or head injury (please describe all)?_____

_____

_____

Please list any medications that your child/teen has taken for an extended period of time for treatment of a medical, health, or emotional/behavioral condition. Exclude medications for routine illnesses (e.g., colds, flu, strep throat).

NAME OF MEDICATION	REASON PRESCRIBED	AGE(S) OF CHILD OR DATES WHEN MED STARTED / ENDED	REASON IT WAS DISCONTINUED
		/	
		/	
		/	
		/	

If your child/teen has used drugs or alcohol, or you suspect that he / she has, please estimate the frequency for each substance using the following scale:
0 = Not at all 1 = Rarely 2 = Sometimes 3 = Many times

SUBSTANCE USE HISTORY	Past	Current
Cigarettes		
Alcohol		
Marijuana		
Huffing/Sniffing		
Cocaine		
Amphetamines/Methamphetamines		
Opiates (codeine, heroin)		
Halluncinogens (LSD, mushrooms)		
Prescription drugs taken other than as prescribed		
Over-the-counter taken other than as intended		
Other (please specify)		

FAMILY HISTORY OF MENTAL HEALTH AND CHEMICAL DEPENDENCY

Condition	Family members (in relation to teen- e.g. mother, uncle, sister)	Condition	Family members (in relation to teen- e.g. mother, uncle, sister)
Problems with inattention, hyperactivity, or impulse control (ADHD/ADD)		Alcohol abuse/dependence	
Learning disabilities		Drug abuse/dependence	
Autism / Asperger's / Pervasive Developmental Disorder		Problems with aggressive, defiant, or oppositional behavior as a child	
Mental Retardation		Depression	
Anxiety disorder (worry, nervousness, panic)		Abuse/trauma	
Obsessive-compulsive Behavior		Arrests/antisocial behavior	
Eating disorder		Suicidal thoughts or attempts	
Psychosis or schizophrenia		Self-harming behavior	
Volatile or Unstable Relationships		Bipolar disorder	

Other (please specify):

_____

_____

EDUCATIONAL HISTORY

Please list the schools that your child/teen attended and rate how well he/she has done at school during those times: 1 = very poor, 2 = poor, 3 = average, 4 = good, 5 = excellent

	Name of School	Years/Grades attended	Rating	Comments
Daycare/Preschool				
Elementary School				
Middle School				
High School				
College/Post-secondary Education				

Please comment on your child's academic strengths and struggles:

_____
_____
_____

How does your child get along with teachers?

_____
_____

How does your child get along with peers?

_____
_____
_____

Does your child receive special services at school? Yes No

If yes, please describe:

_____
_____
_____

In the past, have there been concerns <u>at school</u> about your child? Yes No

If yes, please describe:

_____
_____
_____

At present, are there concerns <u>at school</u> about your child? Yes No

If yes, please describe:

_____
_____
_____

Has your child/teen ever repeated any grades? Yes No

Comments: _____
_____
_____

How easily does your child/teen make friends?

___ More difficult than average ___ Average ___ Easier than average ___ Don't know

How long does this child/teen keep friends?

___ Less than 6 months ___ 6 months – 1 year ___ More than 1 year ___ Don't know

The friends tend to be:

___ Younger ___ Same-aged ___ Older

What hobbies, interests, and leisure activities does your child/teen enjoy?

_____
_____

Describe your child's personality and character traits: _____
_____

SYMPTOM CHECKLISTS

Read each symptom below and decide how much each one applies to your child/teen:
0 = Not at all 1 = Rarely 2 = Sometimes 3 = Many times/Very Often

INATTENTIVENESS	Past Month	In General
Fails to give close attention to details or makes careless mistakes in schoolwork, work, activities		
Has difficulty sustaining attention in tasks or play activities		
Has difficulty listening when spoken to directly		
Does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (behavior is not due to poor comprehension of instructions or defiance)		
Has difficulty organizing tasks and activities		
Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as school or homework)		
Loses things necessary for tasks or activities (such as toys, school assignments, pencils, books, or tools)		
Is easily distracted by things that are not relevant to the task at hand		
Is forgetful in daily activities		
HYPERACTIVITY/IMPULSIVITY	Past Month	In General
Fidgets with hands or feet or squirms in seat		
Leaves seat in classroom or in other situations in which remaining seated is expected (such as meal time, riding in a car, etc.)		
Runs about or climbs excessively in situations in which it is inappropriate, or excessive restlessness given age		
Difficulty playing or engaging in leisure activities quietly		
Is “on the go” or acts as if “driven by a motor”		
Talks excessively		
Blurts out answers before questions have been completed		
Has difficulty awaiting turn		
Interrupts or intrudes on others		
DISRUPTIVE BEHAVIORS - CONDUCT PROBLEMS	Past Month	In General
Bullies, threaten, or intimidate others		
Initiates physical fights		
Has used a weapon that can cause harm		
Has been physically cruel to people or animals		
Has stolen while confronting a victim		
Has forced someone into a sexual activity		
Has deliberately engaged in fire setting		
Swears or uses obscene language		
Has deliberately destroyed others’ property		
Lies to obtain favors or avoid obligations		
Has stolen without confrontation (such as shoplifting or stealing from home)		
Is truant		
Has broken into someone else’s house, building, or car		

0 = Not at all 1 = Rarely 2 = Sometimes 3 = Many times/Very Often

DISRUPTIVE BEHAVIORS – OPPOSITIONAL & DEFIANT	Past Month	In General
Loses temper		
Argues with others		
Actively defies or refuses requests or rules from authority figures		
Deliberately does things that annoy other people		
Blames others for own mistakes		
Is touchy or easily annoyed by others		
Is angry or resentful		
Is spiteful or vindictive		
DEPRESSED MOOD	Past Month	In General
Depressed or irritable mood most of the day, nearly every day		
Diminished interest or pleasure in all or almost all activities, most of day, nearly every day		
Significant weight loss or weight gain, decrease or increase in appetite nearly every day		
Difficulty sleeping or oversleeping nearly every day		
Fatigue or loss of energy nearly every day		
Feelings of worthlessness or excessive or inappropriate guilt nearly every day		
Explosive temper or marked mood swings with minimal provocation		
Agitation or lethargy		
Decreased concentration		
Recurrent thoughts of death		
Suicidal thinking, threats, plan, or attempt		
Self-harming behavior (non-suicidal; i.e., cutting, burning, scratching, etc.)		
ELEVATED MOOD	Past Month	In General
Periods of excited, elevated, or irritable mood (e.g., rages or extreme hyperactivity)		
Periods of abnormal or unrealistic, inflated self-esteem		
Periods of decreased need for sleep (e.g., feels rested after 3 hours of sleep)		
More talkative than usual or pressure to keep talking		
Racing thoughts		
Distractibility		
Periods of high risk activity (unrestrained buying sprees, reckless driving, promiscuous sexual activity, drug or alcohol binges, etc.)		
DISORDERED EATING BEHAVIOR	Past Month	In General
Nutritional restriction or dieting		
Fear of gaining weight		
Binge eating		
Self-inducted vomiting		
Laxative or diuretic use		
Excessive exercise		

0 = Not at all 1 = Rarely 2 = Sometimes 3 = Many times/Very Often

ANXIETY	Past Month	In General
Excessive anxiety or worry		
Recurrent distressing recollections or dreams of a traumatic event		
Brief periods of intense fear or discomfort, characterized by accelerated heart rate, sweating, trembling, shortness or breath, dizziness, or fear of losing control		
Excessive anxiety concerning separation from home or major attachment figures		
Persistent fear of one or more social or performance situations in which the person is exposed in unfamiliar people or to possible scrutiny by others		
Recurrent and persistent thoughts, impulses, or images that are experienced as intrusive and inappropriate, and that cause anxiety or distress		
Repetitive behaviors (e.g., handwashing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly		
OTHER CONCERNS OR SYMPTOMS	**Past Month**	**In General**
Motor or vocal tics		
Odd postures		
Little or no interest in peers		
Starts or ends social interactions inappropriately		
Excessive reaction to changes in routine		
Delayed or abnormal speech		
Bizarre ideas		
Hallucinations		
Arrests/legal history		
Sexual activity		
Purposely causing injury to self		
No fear of strangers		
Preoccupation with violence		
Abuse of internet		
Other (please specify):		

Any additional comments or information that you think would be important for me to know to help understand your child/teen better?