Welcome to Bear River Mental Health Services, Inc. As an important part of your assessment appointment, we ask that you fill out the following information packet as completely as possible. Completion of this packet will greatly assist your therapist in gathering information about your history and developing the assessment and treatment plan.

This packet will be used for informational purposes only and is not considered part of the clinical record. This information will be destroyed after it has been reviewed by the therapist.

If you have questions, please contact our service coordination staff at the appropriate location.
Cache and Rich Counties: 435-752-0750
Brigham City: 435-734-9449
Tremonton Area: 435-257-2168

CHILD & YOUTH PERSONAL HISTORY

Answer all questions as they apply to the <u>Child or Youth</u>

Youth's Legal Name ____________________________ Age _____________ Today's Date ____________________

Youth's Preferred Name _________________________________ Youth's Preferred Pronoun ___________________

Completed by _____________________________________ Relationship to Youth ____________________________

CURRENT LIVING ARRANGEMENTS (Who does the child live with?)

Please list all family members and indicate whether they're living in the home. Please include non-family members who currently live in the home.

Current Living Arrangements				
Name	Age	Relationship to Youth	Living in the home	Occupation or School Grade
			○ No ○ Yes	
			○ No ○ Yes	
			○ No ○ Yes	
			○ No ○ Yes	
			○ No ○ Yes	

PRESENTING PROBLEMS

Please list the problem or problems for which you are seeking help. Begin with the most difficult problem first.

1. ____

   Rate the severity of problem #1: ○ mild ○ moderate ○ severe

2. ____

   Rate the severity of problem #2: ○ mild ○ moderate ○ severe

History of this/these problems____

____

What solutions have already been tried to correct the presenting problems?

____

____

____

DESIRED OUTCOMES OF SERVICE

What are your hopes/goals for this youth to accomplish in treatment (please be specific)?

1. ____
2. ____
3. ____

Current and Past Symptoms Please rate the following symptoms for this youth:

	Never	Almost Never	Some of the time	Most of the time	Almost all the time
Short attention span	○	○	○	○	○
Impulsiveness problems	○	○	○	○	○
Concentration problems	○	○	○	○	○
Difficulty with change	○	○	○	○	○
Irritable	○	○	○	○	○
Aggressive to people or animals	○	○	○	○	○
Destruction of property	○	○	○	○	○
Lying	○	○	○	○	○
Explosive anger	○	○	○	○	○
Breaking Rules	○	○	○	○	○
Depression	○	○	○	○	○
Mood swings	○	○	○	○	○
Low self esteem	○	○	○	○	○
Guilt	○	○	○	○	○
Anxiety and Stress	○	○	○	○	○
Separation anxiety	○	○	○	○	○
Problems sleeping	○	○	○	○	○
Nightmares	○	○	○	○	○
Bed wetting / Day accidents	○	○	○	○	○
Other, please list: ________________________	○	○	○	○	○

SUBSTANCE USE (if applicable)

Has youth ever used the following substances:

	Frequency of use	Length of use (when started)
❑ Cigarettes/Tobacco	______________________	______________________
❑ Alcohol	______________________	______________________
❑ Marijuana	______________________	______________________
❑ Stimulants	______________________	______________________
❑ Pain pills/Muscle relaxers	______________________	______________________
❑ Other _____________	______________________	______________________

Has youth ever received treatment for substance abuse? ○ No ○ Yes

From whom/when: ____

HEALTH HISTORY

Who is the youth's family doctor? ________________________________Phone #: ____________________________

Please list and date any major illness, injury, surgery, and/or hospitalization this youth has had:

____ Date _______________________________

____ Date _______________________________

____ Date _______________________________

List any allergies youth has: ____

Date of last physical exam: _____________________ Date of last dental exam: _____________________

Immunizations are up to date. ○ No ○ Yes

Youth is sexually active. ○ No ○ Yes ○ Unknown

Is (female) youth pregnant? ○ No ○ Yes Due date: ___________________________________

Please check all of the following medical conditions which youth now has or has had in the past:

- ❑ Stomach/Bowel problems
- ❑ Severe headaches
- ❑ Convulsions/Seizures
- ❑ Cancer
- ❑ Hyperactivity
- ❑ Sleep problems
- ❑ Weight gain/loss
- ❑ Appetite problems
- ❑ High or low energy level
- ❑ Diabetes
- ❑ Hypoglycemia
- ❑ Other ____________

Has youth been tested for:					
	TB	○ No	○ Yes	○ Positive	○ Negative
	Hepatitis	○ No	○ Yes	○ Positive	○ Negative
	HIV	○ No	○ Yes	○ Positive	○ Negative

MEDICATIONS

List *any* current medications youth is now taking and dosage:

Medication	Dosage	Prescribing Doctor
___________________________	________________	____
___________________________	________________	____
___________________________	________________	____

List any mental health medications youth has taken in the past:

Medication	Dosage	Date
____	____________________	__________________
____	____________________	__________________
____	____________________	__________________

FUNCTIONING

Are there any concerns for this youth about:

- ❑ Language functioning (speech and hearing): explain ____
- ❑ Visual functioning: explain ____
- ❑ Intellectual functioning: explain ____
- ❑ Learning ability: explain ____

CHILDHOOD DEVELOPMENT / ATTACHMENT HISTORY

When your child was a *toddler* (***1 ½ to 3 years old***):

1. Did your child take an interest in other children? ○ No ○ Yes
2. Did your child ever use his/her index finger to point, to indicate interest in something? ○ No ○ Yes
3. Did your child ever bring objects over to you to show you something? ○ No ○ Yes
4. Did your child imitate you? (e.g., you make a face – will they imitate it?)? ○ No ○ Yes
5. Did you child respond to his/her name when you call? ○ No ○ Yes
6. If you pointed at a toy across the room, did your child look at it? ○ No ○ Yes

Pregnancy and Delivery Information:

- ❑ Mother did not receive prenatal care
- ❑ Any issues or problems during pregnancy: explain ___________________________
- ❑ Prenatal exposure to substances
- ❑ Medications taken by mother during pregnancy: List: ___________________________________
- ❑ Any issues with delivery: __________________

From age 2-5 youth showed:

- ❑ A short interest or attention span
- ❑ Restlessness
- ❑ Frequent temper outbursts
- ❑ Destructive with toys
- ❑ Generally unhappy or irritable
- ❑ Intense reactions, whether positive or negative
- ❑ Inability to adapt to new situations
- ❑ Overly cautious or slow to trust
- ❑ Too quick to trust
- ❑ Rarely sought comfort
- ❑ Rarely involved in other's play
- ❑ Tuned out/loses contact

Please write how old the youth was when they first:

Walked alone ____________ Was toilet-trained ____________ Knew colors _____________

Spoke single words ________ Spoke sentences ____________ Listen to a 10 min story ______

Please describe the initial relationship between the parent(s) and this youth? __________________________________
____

FAMILY HISTORY and FUNCTIONING

Biological parents are: ○ Married ○ Unmarried ○ Separated ○ Divorced ○ One or both are deceased

Was youth adopted? ○ No ○ Yes At what age? __________ From where? _________________

Who has legal custody of youth? ____

Please list any separations from your parents / care givers you may have experienced as a child (ie. placed in foster care, moved from family member to family member, incarceration of parent, death of a parent etc.): __________
____

Please list any residential changes for this youth in the last 5 years _______________________________________
____
____

Family Psychiatric History

Please list any blood relations (e.g., parents, grandparents, aunts, uncles, siblings, etc.) who have had:

Mental or nervous breakdown ______________________________

Depression ______________________________

Anxiety or severe nervousness ______________________________

Alcoholism ______________________________

Drug abuse ______________________________

Mood swings ______________________________

Strange behavior ______________________________

Extreme temper problems ______________________________

Suicide attempt or death by suicide______________________________

Extremely shy, quiet-isolated from others ______________________________

Mental health hospitalization ______________________________

Childhood learning or reading difficulty ______________________________

Serious behavior difficulties in childhood ______________________________

Serious marital disagreements or discipline of children ______________________________

History of parental separation or divorce ______________________________

Significant medical illness (list relative and illness) ______________________________

Is anyone in youth's family receiving mental health services at this time? ○ No ○ Yes

If so, list relationship and where: ______________________________

____

ABUSE / NEGLECT / TRAUMA HISTORY

Has this youth ever experienced any kind of abuse?

Emotional abuse ○ No ○ Yes If yes, by whom? ______________________________

Physical abuse ○ No ○ Yes If yes, by whom? ______________________________

Sexual abuse ○ No ○ Yes If yes, by whom? ______________________________

Has youth ever been involved in any other type of traumatic incidents such as Medical Trauma, Natural Disasters, Refugee Trauma, School Violence, Terrorism, or Traumatic Grief? ○ No ○ Yes

Explain: ______________________________

MENTAL HEALTH TREATMENT HISTORY

1. Has youth ever received previous mental health counseling or treatment? ○ No ○ Yes

Therapist ______________________________ When ______________

Regarding ______________________________

Therapist ______________________________ When ______________

Regarding ______________________________

2. Has youth ever been hospitalized for mental health reasons? ○ No ○ Yes

Where ______________________________ When ____________________

Where ______________________________ When ____________________

CULTURAL / ETHNIC INFORMATION

Religious Preference (optional): ____

Please list (describe) any information that is unique about this youth or his/her family that would be helpful for the therapist to be aware of, i.e. religious views/beliefs, family heritage, family traditions, cultural beliefs:

____

____

____

____

EDUCATIONAL HISTORY / CHALLENGES / BARRIERS

What school is youth attending? ____

Current Grade level (please circle): Preschool Kindergarten

1 2 3 4 5 6 7 8 9 10 11 12

Please check all that apply.

- ❑ Autistically Impaired
- ❑ Learning disabilities
- ❑ Emotional problems
- ❑ Resource classes
- ❑ Has IEP
- ❑ School behavior problems

Grade Point Average (if applicable): __________

Math is: ○ strong ○ average ○ weak

Reading is: ○ strong ○ average ○ weak

Strongest subject: ____

Weakest subject: ____

Does the youth have a job? ○ No ○ Yes Describe: ____________________

SOCIAL HISTORY

Mark number of friends youth has: ○ More than 10 ○ 10 - 3 ○ 2 - 1 ○ None

Peers are a positive influence: ○ No ○ Yes

Difficulties with friends/peers: ____

CRIMINAL / LEGAL HISTORY

Has the youth ever been in trouble with the law or convicted of a crime: ○ No ○ Yes

Is the youth on probation: ○ No ○ Yes

OTHER AGENCY INVOLVEMENT

Check agencies in which youth or family is currently involved or has been in the past.

- ❑ Department of Child & Family Services
- ❑ Juvenile Court
- ❑ Adolescent Probation
- ❑ Health Department – Substance Abuse
- ❑ Youth Corrections
- ❑ Special School Services
- ❑ Department of Services for People with Disabilities
- ❑ Center for Persons with Disabilities
- ❑ Other Agency

SUICIDE / OTHER RISK ASSESSMENT

1. Is youth thinking about or planning suicide or harming themselves now? ○ No ○ Yes
   If yes, please explain: ____
   ____

2. Has youth ever attempted suicide or to harm themselves in any way? ○ No ○ Yes
   If yes, please explain: ____
   ____

3. Has youth physically or sexually assaulted someone else? ○ No ○ Yes
   If yes, please explain: ____
   ____

STRENGTHS and NATURAL SUPPORTS

Please list youth's positive strengths and/or best ways to cope: ____

____

____

____

____

Additional Information:

____

____

____

jw/forms/clinical/children/Personal History YOUTH Oct 2023