Center for Wellness and Recovery
an Affiliate of Mountain View Hospital

FIND YOUR DIRECTION

2141 CORONADO ST. IDAHO FALLS, ID 83404 / (208)-523-3857

*Please complete this form with the help of your child and bring to your first appointment.
This information is fundamental to the assessment and treatment process.

PATIENT CONTACT INFORMATION

Name_____Age_____Date of birth_____

_____

Parent/Guardian Name(s):_____

Person completing form: _____ Relationship to child: _____

Phone (___)_____ Mailing Address_____

Emergency contact name_____Relationship to emergency contact_____Phone (___)_____

PRESENTING PROBLEMS AND CONCERNS

Describe the concern that brought you here today: _____

_____

_____

What has led you to seek help for this concern at this time? _____

_____

_____

Have you already tried to resolve this concern? If so, what did you do and how did it work? _____

_____

_____

How has this concern affected the family? _____

_____

_____

Please describe any stressors that may be affecting your child today (divorce, relationship changes, unemployment, school, peers, losses, etc.). Note changes in your child's mood or behavior as a result of these stressors: _____

_____

_____

Please check all your child's behaviors and symptoms that you consider problematic:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/Confusion
- ☐ Sadness/Depression
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self-worth
- ☐ Fatigue
- ☐ Recurring disturbing memories
- ☐ Alcohol use
- ☐ Change in appetite
- ☐ Withdrawal from people
- ☐ Anxiety/Worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Phobias
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Racing thoughts
- ☐ Wide mood swings
- ☐ Suspicion/Paranoia
- ☐ Hearing voices
- ☐ School failure
- ☐ Substance use
- ☐ Visual hallucinations
- ☐ Defiance
- ☐ Aggression/Fights
- ☐ Homicidal thoughts
- ☐ Frequent arguments
- ☐ Irritability/Anger
- ☐ Peer/Sibling conflict
- ☐ Stealing
- ☐ Destroys property
- ☐ Running away
- ☐ Swearing
- ☐ Curfew violations
- ☐ Lying
- ☐ Truancy
- ☐ Sexual behavior

What areas of functioning are being impacted by your child's behavior and symptoms?

- ☐ Handling everyday tasks
- ☐ Work/School
- ☐ Recreational activities
- ☐ Self-esteem
- ☐ Housing
- ☐ Health
- ☐ Relationships
- ☐ Legal matters
- ☐ Other:
- ☐ Hygiene
- ☐ Finances

SAFETY CONCERNS

Has your child ever thought about hurting or killing him/herself, or had an impulse to do so? ☐ Yes ☐ No
If yes, does he/she have a suicide plan? ☐ Yes ☐ No
If so, please explain: _____

_____

_____

If your child has a plan, does he/she have the intention of acting on his/her plan? ☐ Yes ☐ No
If so, please explain: _____

_____

_____

What are your child's reasons for living? _____

_____

_____

Has your child ever tried to hurt or kill him/herself? ☐ Yes ☐ No
If yes, list the date(s), method(s) and how he/she was rescued: _____

_____

_____

Has your child ever harmed property, other people or thought seriously about causing harm to someone? ☐ Yes ☐ No
If yes, please explain: _____

_____

_____

Is your child having thoughts of harming someone right now? ☐ Yes ☐ No
If yes, please explain: _____

_____

_____

Are there firearms in your home? ☐ Yes ☐ No
How many and of what type (pistol, revolver, rifle, automatic)? _____

_____

_____

Do the children in your home have access to these firearms? ☐ Yes ☐ No

Are these firearms stored unloaded and locked with trigger guards? ☐ Yes ☐ No (Trigger guards are free of charge from local police departments)

Is the ammunition (bullets) kept in a separate location? ☐ Yes ☐ No

Has your child recently been physically hurt or threatened by someone else? ☐ Yes ☐ No
If yes, please describe: _____

_____

_____

Has your child talked to you about the safety concerns above? ☐ Yes ☐ No
If yes, who: _____
_____

When did your child tell you and what was your response? _____
_____
Who have you told and what has been their response? _____
_____
_____

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Other relatives			

Family Mental Health History	Who?
Major Depressive Disorder	
Bipolar Disorder	
Posttraumatic Stress Disorder	
Obsessive Compulsive Disorder	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	
Personality Disorder	
Suicidal Action/Completion	
Victim of Abuse	
Abusive/Domestic Violence	
Other:	

Please describe your child's living situation. Check all that apply:

☐ With biological parents ☐ With another relative: ☐ With foster parents
☐ With adoptive parents ☐ In an institution/group home ☐ Other:

Please check most appropriate description of parental marital status:

☐ Parents legally married or living together ☐ Mother remarried Number of times _____
☐ Parents temporarily separated ☐ Father remarried Number of times _____
☐ Parents divorced or permanently separated

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

☐ Emotional abuse ☐ Neglect ☐ Lived in a foster home
☐ Sexual abuse ☐ Violence in the home ☐ Multiple family moves
☐ Physical abuse ☐ Crime victim ☐ Homelessness
☐ Parent alcohol or substance abuse ☐ Parent serious illness ☐ Loss of a loved one
☐ Teen pregnancy ☐ Placed a child for adoption ☐ Financial problems
☐ Abortion ☐ Other: ☐ Other:

Were there any medical problems during the pregnancy or birth of your child? ☐ Yes ☐ No If yes, please describe:
_____

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

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

ACADEMIC INFORMATION

Current grade/placement: _____

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

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

☐ Suspension/Expulsion	☐ Incomplete homework	☐ Learning difficulties
☐ Referrals/Detention	☐ Poor grades	☐ Teased or Bullied
☐ Speech	☐ Truancy	☐ Gang involvement
☐ Hearing	☐ Seeing	☐ Attention
☐ Reading	☐ Writing	☐ Math
☐ Held back	☐ IEP/Special Education	☐ Other:

Does your child have an after-school provider? ☐ Yes ☐ No If so, who?
_____

Has your child ever repeated or skipped a grade? ☐ Yes ☐ No If yes, which one(s)? _____

Has your child ever received Special Education services? ☐ Yes ☐ No If yes, please describe services received and reason for services:
_____

What does your child's teacher(s) say about him/her? _____
_____
_____

PREVIOUS MENTAL HEALTH TREATMENT

		Type of Treatment	When?	Provider/Program	Reason for Treatment
☐ Yes	☐ No	Outpatient psychotherapy			
☐ Yes	☐ No	Psychiatric medication			
☐ Yes	☐ No	Psychiatric hospitalization			
☐ Yes	☐ No	Addiction treatment			
☐ Yes	☐ No	Self-help/Support groups			

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								
PCP/LSD								
Spice								
Bath Salts								
Prescription Pain Medications								
Prescription Anxiety Medications								

☐ Yes ☐ No Has your child had withdrawal symptoms when trying to stop using any alcohol or any other substances? Ifyes, please describe:

☐ Yes ☐ No Has your child ever had problems with work, relationships, health, the law, etc. due to his/her alcohol or substance use? If yes, please describe:

MEDICAL INFORMATION

Does your child have a primary care clinic or medical provider? ☐ Yes ☐ No

Name of clinic or provider _____

Phone (_____)_____ Fax (_____)_____

Has your child had a physical exam to check for medical reasons for his/her symptoms? ☐ Yes ☐ No

Date of his/her last physical exam _____

In the past year, has your child had screening or testing for the following?

☐ **Vision.** If so, does your child have or need glasses or contact lenses? ☐ Yes ☐ No

☐ **Hearing.** If so, does your child have or need a hearing aid? ☐ Yes ☐ No

If a doctor has prescribed visual or hearing aids, does the child wear them? ☐ Yes ☐ No ☐ N/A

Has your child experienced any of the following medical conditions during his/her lifetime?

☐ Allergies	☐ Asthma	☐ Headaches	☐ Stomach aches
☐ Chronic pain	☐ Surgery	☐ Serious accident	☐ Head injury
☐ Dizziness/fainting	☐ Meningitis	☐ Seizures	☐ Vision problems
☐ High fevers	☐ Diabetes	☐ Hearing problems	☐ Miscarriage
☐ Sexually transmitted disease	☐ Abortion	☐ Sleep disorder	☐ Other:

Please list any CURRENT medical concerns:_____

_____

_____

_____

_____

Does your child have a psychiatric provider? ☐ Yes ☐ No

Name of provider_____

Phone (_____)_____Fax (_____)_____Date of last visit: _____

If so, why are you seeking services at our center? _____

_____

_____

Current prescription medications: ☐ None

	EXAMPLE	Medicine #1	Medicine #2	Medicine #3	Medicine #4	Medicine #5	Medicine #6

Name of medicine	Celexa						
How many milligrams (mg)?	40 mg						
How many pills do you take at a time?	one						
How many times a day do you take this medicine?	once						
What time of day do you take this medicine?	morning						
What does this medicine treat?	depression						
Name of prescriber	Dr. John Smith						

If you need more space, please attach another sheet of paper.

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____
_____
_____
_____

Allergies and/or adverse reactions to medications: ☐ None
If yes, please list: _____
_____
_____

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

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

- ☐ Family ☐ Neighbors ☐ Friends ☐ Students/Co-workers
- ☐ Support/Self-Help Group: _____ ☐ Community Group: _____
- ☐ Religious/Spiritual Group: _____ ☐ Cultural/Ethnic Group: _____

If your child is experiencing any difficulties due to interpersonal, social or cultural issues, please describe:_____
_____
_____

Do you have concerns about your child's friends? ☐ Yes ☐ No If yes, please explain: _____
_____

Does your child have a best friend? ☐ Yes ☐ No If no, please explain: _____
_____

Is your son/daughter dating? ☐ Yes ☐ No If this is a concern, please explain: _____
_____

How important are interpersonal, social, or cultural issues matters to your child?

☐ Not at all ☐ Very little ☐ Somewhat ☐ Very Much

Would you like these perspectives and concerns to be incorporated into your services? ☐ Yes ☐ No

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

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.):_____
_____

LEGAL INFORMATION

Have you ever been convicted of a misdemeanor or felony? ☐ Yes ☐ No If yes, please explain: _____
_____
_____

Are you currently involved in any divorce or child custody proceedings? ☐ Yes ☐ No If yes, please explain the current child custody/visitation arrangement and/or status of the proceedings: _____
_____
_____

Has your child ever been a ward of the court with DWH or IDJC guardianship? ☐ Yes ☐ No If yes, please explain: _____
_____
_____