Catalpa Health®
Mental Health & Wellness For Kids

Client and Family History Form

Who referred you to Catalpa? _____

Form completed by: _____ Date form was completed: _____

Client's name: _____ Client's preferred name: _____

Client's date of birth: _____ Gender: M ☐ F ☐ Other ☐ Race/Ethnicity:_____

Names of Parents or Guardians: _____ Was your child adopted? ___No ___Yes

Who has parental rights for this child? Mother _____ Father _____ Other (legal guardian, county, etc.)_____

Are there any legal reasons either parent or guardian cannot be present or alone with a child? ___No ___Yes, explain: _____

_____

Important client and family cultural information:_____

Please describe the child's/adolescent's assets and strengths: _____

_____

CATALPA HEALTH CHILD & ADOLESCENT SYMPTOM CHECKLIST

DURING THE PAST 6 MONTHS, has the patient experienced any of the following symptoms?

	None	Mild	Moderate	Severe	Past
Depressed or unusually sad					
Irritable					
Loss of interest in previously enjoyable activities					
Loss of appetite					
Overeating					
Difficulty with sleep					
Suicidal thought(s)					
Aggressive or violent thought(s)					
Self-injuring behaviors					
Feelings of worthlessness and/or hopelessness					
Loss of energy					

	None	Mild	Moderate	Severe	Past
Hears voices that others can't/sees things others do not					
Has bizarre thoughts that others cannot understand or believe					

	None	Mild	Moderate	Severe	Past
Worries excessively about multiple things					
Excessive anxiety when performing in front of others					
Excessive worry about being teased by peers					
Social situations are avoided or endured with intense anxiety					
Upset/worries when separating from parents/caregiver/home					
Worries about getting lost or kidnapped					
Physical/bodily complaints					

Intense fear of a specific object or situation					
Obsessive/recurrent thoughts (e.g., health concerns, etc.)					
Repetitive behaviors (e.g., hand washing, doing things 3 times)					

	None	Mild	Moderate	Severe	Past
Seeing, feeling or hearing something bad that happened in past					
Is easily startled					
Always feels on guard					

	None	Mild	Moderate	Severe	Past
Has difficulty paying attention (in play, school, other activities)					
Requires multiple reminders when given directions					
Appears to act before thinking					
Does not follow instructions					
Is forgetful or loses things					
Easily distracted					
Is fidgety or squirms or can't stay in seat					
Runs or climbs excessively, is hyperactive					
Talks excessively					
Has difficulty waiting turn					
Interrupts or intrudes on others					

	None	Mild	Moderate	Severe	Past
Refuses to eat					
Eats a lot and then vomits					

	None	Mild	Moderate	Severe	Past
Smokes cigarettes, drinks alcohol, or abuses alcohol					

	None	Mild	Moderate	Severe	Past
Bullies, threatens, or intimidates others					
Initiates physical fights					
Has been physically cruel to animals					
Has shoplifted or stolen items					
Has deliberately set fires					

	None	Mild	Moderate	Severe	Past
Has deliberately destroyed others' property					
Lies to obtain goods or to avoid obligations					
Has run away from home overnight on at least two occasions					
Is truant from school					
Actively defies or refuses to comply with adult rules					
Deliberately annoys others					
Blames others for his/her mistakes or misbehavior					
Easily annoyed by others					
Is spiteful or vindictive					

	None	Mild	Moderate	Severe	Past
Avoids eye contact with others					
Unusual preoccupation with objects or routines					
Does not like changes					
Hand–flapping, shrieks, puts objects in mouth					
Failure to initiate or respond to social interactions					
Makes repetitive movements and is unaware of it					

FAMILY MENTAL HEALTH INFORMATION

Please ✓ any of the below that apply.

MENTAL HEALTH	MOTHER	FATHER	SIBLING	GRANDPARENT	OTHER
Depression					
Bipolar (Manic-Depression)					
Psychosis or Schizophrenia					
ADHD					
OCD or Obsessive Compulsive					
Anxiety					
PTSD					
Autism					
Alcohol or Drug Abuse					
Suicidal Thoughts or Behaviors					
Other Mental Health:					

PAST MENTAL HEALTH TREATMENT

Has your child been given any previous mental health diagnoses?_____ No _____ Yes, explain: _____

_____

Has your child been to counseling in the past? _____ No _____ Yes, Dates: _____

Has your child been hospitalized for psychiatric reasons? ____ No ____ Yes, Dates & Hospital: _____

_____

DEVELOPMENTAL HISTORY

During pregnancy, did the mother experience any illness or complications? _____ No _____ Yes, explain:_____

Did your child have any complications at birth or as an infant/toddler? _____No _____Yes, explain: _____

_____

Was your child born prematurely? _____ No _____Yes How many weeks at birth _____ Weight at birth _____

Has your child's doctor, caregiver or teacher expressed any developmental concerns in the below areas?

_____ Crawling _____ Walking _____ Speaking _____Toilet training

Please list any significant medical issues: _____

_____

Please list all <u>CURRENT</u> medications child is taking:

Please include prescriptions, over-the-counter, herbs, vitamins, or suspected illegal drugs

NAME OF MEDICATION	DOSAGE & FREQUENCY	DATE BEGAN TAKING MEDICATION	WHO PRESCRIBED THE MEDICATION?

FAMILY AND SOCIAL HISTORY

Family currently living in home:

NAME OF FAMILY MEMBER	AGE	RELATIONSHIP

Parent(s) and Siblings *not* living in home:

NAME OF FAMILY MEMBER	AGE	RELATIONSHIP

Does your child get along well with you and/or other caregivers? _____ Yes _____ No _____ Unsure

If " no" or "unsure", please explain: _____

Parent 1: _____Mother _____Father
Date of Birth: _____
Occupation: _____
Employer: _____

Parent 2: _____Mother _____Father
Date of Birth: _____
Occupation: _____
Employer: _____

Parent 3: _____ NA _____Stepmother _____Stepfather
Date of Birth: _____
Occupation: _____
Employer: _____

Parent 4: _____ NA _____Stepmother _____Stepfather
Date of Birth: _____
Occupation: _____
Employer: _____

Child's involvement in social and/or extracurricular activities: _____

_____

Circle any of the below options that best describes your child socially:

Makes friends easily Maintains friendships Socially withdrawn Has few but close friends Frequent peer conflict

List any of your child's current or past legal issues: _____

EDUCATIONAL HISTORY

Patient's current grade level: _____ Current School: _____

_____ Regular Ed _____ Special Ed Type of IEP: (Please circle) LD, EBD, CD, S/L, OHI, Autism, TBI

Does your child have a history of learning challenges? Please include grades and specific challenges. _____

_____

_____