Atlanta Specialized Care

PATIENT SELF-REPORT: CHILD/ADOLESCENT (18 AND UNDER ONLY)

Patient Name:_____Age:___ Date:____
Name of person completing this form (if not patient)_____
1. Briefly describe the problem which brought you here today:_____
_____
_____

2. Is the patient having thoughts of hurting themselves or someone else?
YES NO If yes, please explain:_____
_____
Has the patient ever had thoughts of hurting themselves or someone else?
YES NO

THERAPIST COMMENTS

PAST AND CURRENT TREATMENT

3. Has the patient ever been treated for psychiatric, substance abuse, emotional, or behavioral problems in the past? YES NO If yes, when, where, and with whom?_____
Did you find past treatment helpful? YES NO

4. Is the patient currently under the care of a psychiatrist, therapist, school counselor, or pediatrician for a psychiatric problem? YES NO

5. Has the patient ever taken psychiatric medications in the past? YES NO If yes, please list name(s) and dosage(s):_____
_____

6. Is the patient currently taking any psychiatric medications? YES NO
If yes, please list name(s) and dosage(s):_____
_____

FAMILY'S TREATMENT

7. Have any of the patient's family members currently or in the past been under the care of a psychiatrist or therapist? YES NO If yes, which family member and for what reason?_____

MEDICAL PROBLEMS

8. Does the patient have any current medical problems? YES NO If yes, please explain:_____

9. Has the patient ever had any significant medical problems in the past? YES NO If yes, please explain:_____

THERAPIST COMMENTS

_____

10. Are immunizations up to date? YES NO

11. Are there any allergies or medication allergies? YES NO
If yes, please list:_____

12. Is the patient currently taking medication for medical problems?
YES NO If yes, please list medication, dosage, and purpose:

_____

13. Does the patient have a history of head injury, seizures, loss of consciousness, or extended high fevers? YES NO If yes, please list:_____

14. Would you like information from today's visit communicated with your pediatrician or any other medical doctor? YES NO

DEVELOPMENTAL FACTORS

15. Were there problems with pregnancy or delivery? YES NO
If yes, please describe:_____

16. Was there any exposure to alcohol, tobacco, or other drugs during pregnancy? YES NO If yes, please describe:_____

_____

17. Did the patient have any problems with walking, talking, toilet-training, or other developmental milestones? YES NO If yes, please explain:

_____

SUBSTANCE ABUSE

18. Does the patient use (or do you suspect that the patient uses) any alcohol or drugs? YES NO

19. Does the patient currently attend support groups? YES NO

20. Does anyone in the patient's household have any substance abuse problems? YES NO

21. Circle any of the following that the patient has used in the past 30 days: alcohol, tobacco, marijuana, tranquilizers, sleeping pills, pain killers, heroin, cocaine/crack, methamphetamines/speed, LSD, PCP, Ecstasy, inhalants.

22. Have there been any problems related to substance abuse (school/legal/DUI)? YES NO

THERAPIST COMMENTS

LEGAL ISSUES

23. Does the patient have/had problems with school or the juvenile justice system? YES NO

24. Is the patient currently on probation or parole? YES NO

25. Are there any legal issues such as: (Please check)
__Divorce in process __Possible custody battle
__Going to court

26. Is a DFACS worker involved? YES NO

EDUCATIONAL/WORK CONCERNS

27. Are grades…__average, __above average, or __below average?

28. Has there been a significant drop in grades recently? YES NO

29. Check all that apply:__learning disabilities, __developmental disabilities, __special education, __alternative school, __home school.

30. List grade and name of school:_____

31. Please circle current educational/job status: current student, GED, part-time job, full-time job.

32. List any problems related to hearing/speech/vision:_____
_____

33. Has the patient had a psychological evaluation/testing done in school?
YES NO

34. Does the patient have an IEP in effect? YES NO

FAMILY/RELATIONSHIPS

35. Please list anyone who lives in the home, his/her age, and relationship:
_____

36. List other extended family involved with the patient: _____
_____

THERAPIST COMMENTS

37. Are both biological mother/father in the home? YES NO
If no: __divorced __separated __single parent family
__stepfamily __other

38. If divorced, what are the custody arrangements?_____
_____
Does the patient have contact with the parent they do not live with?
YES NO If yes, please describe how often_____
_____

39. Does anyone in the patient's immediate or extended family have psychiatric, emotional, substance abuse, or behavioral problems? YES NO
If yes, please describe:_____
_____

40. Has the patient survived any sexual or physical abuse? YES NO

41. Has the patient witnessed any domestic violence? YES NO

42. Is the patient's support network: Good Moderate Poor

43. What are the patient's hobbies/interests?_____
_____

44. Are there difficulties or concerns about how the patient gets along with other people? YES NO

45. Does the patient have any sexual orientation/gender issues or concerns? YES NO

46. Are there any transportation or financial concerns that would impact treatment? YES NO

_____

Patient (or person completing this form) signature Date

I have reviewed and discussed this information with the patient.

_____

Therapist Signature/Credentials Date