FHW BEHAVIORAL HEALTH

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PSYCHOSOCIAL HISTORY QUESTIONNAIRE – CHILD / ADOLESCENT

Note: This questionnaire refers to "the client" and "the child." We recognize that depending upon age and ability, these questions may be answered by a parent/guardian or the client.

INSTRUCTIONS

1. The following questionnaire is designed so that our behavioral health providers can get to know you better and understand issues that may relate to your mental and emotional health. This will be important in making decisions about best care and treatment options.

2. This new patient paperwork must be completed before an appointment can be scheduled. You can return this paperwork by fax or in-person. You may also mail it to our hospital mailing address at Behavioral Health Dept, Family Health West, PO Box 130, Fruita, CO 81521. If you prefer, an electronic version on our website is also available.

3. Some of the questions are of a sensitive or personal nature. The provider and office staff will safeguard your privacy in compliance with current legal and ethical standards and will release information only to other professionals whom you have authorized and for whom you have signed consent. Please note that there are limitations to confidentiality when your safety or the safety of others may be compromised, and you can discuss any questions you might have about this with your provider.

4. Read each of the items carefully and answer honestly. If you are not certain of an answer, please give your best response. Be aware that your answers may be compared with information obtained from other medical records.

5. Some items may ask for information that you have already answered on this or on other medical forms or questionnaires. We apologize for the repetitiveness. Please answer these items anyway.

6. If an item seems unclear or if you have questions, you may make a notation on the questionnaire or ask the provider directly.

7. Thank you for your cooperation in filling out this form accurately and completely.

Section 1
Identifying Information

Patient Information

Patient's Legal Name: _____ **SSN:** _____

Patient's Preferred Name *(Nickname)* _____ **DOB:** _____

Legal Sex: ❑ Male ❑ Female **Sex Assigned at Birth:** ❑ Male ❑ Female ❑Choose not to disclose

Sexual Orientation: ❑ Straight/ Heterosexual ❑ Gay ❑ Lesbian ❑ Bisexual ❑ Choose not to disclose

❑ Other: _____

Gender Identity: ❑ Male ❑ Female ❑ Transgender Male ❑Transgender Female ❑ Choose not to disclose
❑ Other: _____

Address: _____ **Home Phone:** _____

City: _____ **Work Phone:** _____

State:_____ **Zip:** _____**Mobile:** _____

Email Address: _____ ❑ **No Email** ❑ **Access to MyChart Portal**

Communication Preferences

I choose the following methods as my preferred communication methods for the options below:

To Do: *Tasks to help with your treatment plans and health goals*	[redacted]		❑ Text	❑ Email	[redacted]
FHW News and Information: *Information from your Healthcare Provider*	❑ Mail	❑ Phone Call	❑ Text	❑ Email	❑ MyChart
Account Updates: *Account management and account alerts*	[redacted]		❑ Text	❑ Email	[redacted]
Telehealth Visit Alerts/ Reminders:			❑ Text	❑ Email	
Appointment Notifications:	❑ Mail	❑ Phone Call	❑ Text	❑ Email	❑ MyChart
Billing Updates:	❑ Mail	[redacted]	❑ Text	❑ Email	[redacted]
Health Record Notifications/ Updates:	❑ Mail	❑ Phone Call	❑ Text	❑ Email	❑ MyChart
FHW Updates and Messages: *Receive updates from the FHW Organization*	❑ Mail	❑ Phone Call	❑ Text	❑ Email	❑ MyChart

Additional Demographics:

Marital Status: ❑ Single ❑ Significant Other ❑ Married ❑ Common Law ❑ Divorced ❑ Legally Separated ❑Widowed ❑ Patient Refused

Religion: ❑ Catholic ❑ Christian ❑ Church of Jesus Christ of Latter-Day Saints ❑ Orthodox Jew ❑ Jehovah's Witness ❑ None ❑Patient Refused ❑ Other: _____

Ethnicity: ❑Mexican, Mexican American, or Chicano/a ❑ Non-Hispanic ❑ Other Hispanic, Latino/a, or Spanish origin ❑ Patient Refused

Race: ❑ White or Caucasian ❑ Native American ❑ Alaskan Native American ❑ Black or African American ❑ Asian ❑ Patient Refused ❑Other: _____

Preferred Pharmacy:

❑ City Market Orchard Mesa	❑ Walgreens West Park Dr.	❑ Walmart Rimrock Ave
❑ City Market Clifton	❑ Walgreens Clifton	❑ Walmart North Ave
❑ City Market N 12th Street	❑Walgreens North Ave	❑ Walmart Warrior Way
❑ City Market 24 Road	❑ Walgreens Fruita	❑ Safeway Horizon Dr.
❑ City Market Fruita	❑ Target (CVS)Hwy 6 and 50	❑ Safeway F Rd

❑ Other: _____

Preferred Spoken Language: ❑ English ❑ Spanish ❑ Other: _____

Preferred Written Language: ❑ English ❑ Spanish ❑ Other: _____

Language and Interpreter Info: Need Interpreter? ❑ No ❑ Yes **Hard of Hearing?** ❑ No ❑ Yes

Low Vision? ❑ No ❑ Yes

Additional Patient Information:

Employment Status: ❑ Disabled ❑ Full Time ❑ Not Employed ❑ On Active Military Duty ❑ Part Time

❑ Previous Employer ❑ Retired ❑ Self Employed ❑ Student – Full Time ❑ Student – Part Time

Employer: _____ Employment Date: _____

Occupation: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Patient's Emergency Contact:

Name:_____ Relationship: _____

DOB:_____ Legal Guardian: ❑ Yes ❑ No Emergency Contact: ❑ Yes ❑ No

Address:_____

City: _____State: _____ Zip: _____

Preferred Phone: ❑ Home ❑ Mobile Number: _____

Preferred Written Language: _____Preferred Spoken Language: _____

Interpreter needed? ❑ Yes ❑ No Notify on Admission? ❑ Yes ❑ No

Authorized to receive letters about patient? ❑ Yes ❑ No

Authorized to have MyChart Proxy? ❑ Yes ❑ No

If you would like us to be able to speak to another party about your appointments and account, please list

Name:_____ Phone#: _____

Patient Care Team:

Primary Care Provider: _____

Office: _____

Receive Notifications about Admissions? ❑ Yes ❑ No

Receive Result Notifications? ❑ All Results ❑ Abnormal results only ❑ No results

Section 2
Referral Information

Who referred you or recommended that you make the appointment? _____

Briefly describe the problem(s) that prompted you to come in at this time:

_____

_____

Which of the following are you most interested in?

❒ Psychiatric medication ❒ Psychological testing or diagnostic clarification ❒ Counseling/therapy

Please describe the symptoms or problems that are of most concern to client:_____

_____

When did these problems start?_____

_____

Have they gotten worse over time? Please describe:_____

_____

In your opinion, what are the major causes of the difficulties?_____

_____

Describe the client's strengths:_____

_____

Describe some of client's weaker areas:_____

_____

Has the client had a psychological evaluation before? □ No □ Yes, Dates:_____

Psychologist:_____

Tests given:_____

_____

Outcomes/diagnosis:_____

Are you willing to sign a release? □ Yes □ No, reason: _____

Is this treatment or evaluation subject to litigation of any kind? □ No □ Yes: _____

Section 3
Family Information

FAMILY

Parents:
Mother's name: _____ Age: _____ Highest Education: _____
Occupation: _____

Father's name: _____ Age: _____ Highest Education: _____
Occupation: _____

Parents are: □ married □ separated □ remarried □ deceased □ divorced (custody arrangements: _____
_____)

Child is: □ biological □ adopted (at age: _____) □ foster (since age: _____)

Siblings: (names/ages):_____
_____
How does the client get along with them? _____

Others living in the home (names, ages, relationship):_____
_____
Childcare arrangements (if needed: what type? Hours/days?)_____
_____
Has the client experienced death or separation from a loved one? Describe:_____
_____
Are there any significant family or marital conflicts? Explain:_____
_____
Are there any current or previous legal issues in the family? □ No □ Yes: _____

Please check any of the following that have been part of your family's experience:

❒ Emotional abuse
❒ Sexual abuse
❒ Physical abuse
❒ Neglect
❒ Violence in the home
❒ Unsafe neighborhood
❒ Birth of a sibling
❒ Victim of a crime
❒ Immigration challenges
❒ Racism
❒ Parental remarriage
❒ Parent alcohol or drug abuse
❒ Loss of a parent
❒ Parent or sibling illness
❒ Parent separation/divorce
❒ Foster placement
❒ Unemployment
❒ Loss of a sibling
❒ Inadequate healthcare
❒ Violence in the home
❒ Other forms of oppression
❒ Parental infidelity
❒ Poverty
❒ Multiple family moves
❒ Homelessness
❒ Discord with siblings
❒ Teenage pregnancy
❒ Academic problems
❒ Arrest or incarceration
❒ Illiteracy
❒ Estranged family relationships
❒ Death or loss of a friend

Anything else significant you think we should know? _____
_____

Section 4
Developmental History

PREGNANCY AND BIRTH HISTORY

Age of mother (_____) and father (_____) at client's delivery.
How many prior pregnancies? _____ How many prior miscarriages? _____
Fertility specialist consulted? □ No □ Yes, which procedure: _____

Known health problems of mother during pregnancy: □ Vaginal bleeding □ Toxemia □ Trauma □ Hypertension
□ Gestational diabetes □ Fever/rash □ Blood incompatibility □ Injury □ Other: _____

Did mother use tobacco during pregnancy? □ No □ Yes, how often? _____
Was there tobacco use in the home? □ No □ Yes, how often? _____
Did mother drink alcohol during pregnancy? □ No □ Yes, how often? _____
Did mother use other substances during pregnancy? □ No □ Yes, (what, how much, how often)?_____
_____

List any medications used during pregnancy and frequency: _____

Delivery was: □ Vaginal □ Cesarean (reason_____)
Labor was: □ Spontaneous □ Induced □ Easy □ Moderate □ Hard

Baby was: □ Full term □ Premature (_____ weeks' gestation)
Birth weight: _____ pounds _____ ounces

Was labor prolonged? □ No □ Yes, how long? _____
Were forceps used during delivery? □ No □ Yes

Any birth complications: □ Cord around neck □ Meconium staining □ Lack of oxygen/blue □ Feet first
□ Jaundice/yellow Describe: _____
Did baby breathe spontaneously? □ No □ Yes Oxygen required? □ No □ Yes
Other interventions required? □ No □ Yes, explain: _____
Did baby stay in the intensive care nursery? □ No □ Yes, length of stay? _____ Baby's age at discharge? _____
Medical problems at discharge? _____
List any problems in the first few months of life:_____
_____
Did the mother experience any postpartum depression? □ No □ Yes, interventions? _____

MOTOR

Age sat alone: _____ Crawled: _____ Stood alone: _____ Walked alone: _____
Was the child slow to develop motor skills or awkward compared to siblings/friends (e.g., running, skipping, climbing, riding a bike, playing ball)? □ No □ Yes, explain? _____
How is the child's handwriting? _____
Was physical or occupational therapy ever recommended? □ No □ Yes, length: _____
Any current motor or coordination issues: _____

SPEECH/LANGUAGE

Age child spoke first word: _____ Put 2-3 words together: _____ Speech delays or problems (e.g., stuttering or articulation problems)? □ No □ Yes, describe: _____
Was speech therapy ever recommended/pursued? □ No □ Yes, length: _____
Was the child slow to learn the alphabet? □ Yes □ No Was the child slow to learn the names of colors? □ Yes □ No
Was the child slow to learn to count? □ Yes □ No Other languages spoken in the home, besides English: _____
Language child speaks with parents: _____ Siblings: _____ Friends: _____

TOILETING

Age when toilet trained: _____
Did the child ever have: □ Problems with bedwetting □ Urine accidents □ Soiling/fecal accidents
If yes, at what age: _____ Any current problems with toileting? _____

ADAPTIVE

As an infant, to a significant degree, were any of the following present during the first two years of life?

□ Did not enjoy cuddling	□ Was not calmed by being held or stroked	□ Difficult to comfort
□ Colic	□ Excessive restlessness	□ Poor sleep
□ Head banging	□ Difficulty nursing	

Section 5
COGNITIVE, EMOTIONAL, AND BEHAVIORAL FUNCTIONING

CURRENT SYMPTOM CHECKLIST

Rate the intensity of the symptoms present in the last two weeks.

***None**: This symptom is not present.*
***Mild**: This symptom is currently impacting my quality of life, but not significantly impairing my day-to-day functioning.*
***Moderate**: This symptom is significantly impacting my quality of life and/or day-to-day functioning.*
***Severe**: This symptom is profoundly impacting my quality of life and/or day-to-day functioning.*

Symptom	None	Mild	Moderate	Severe
Anxious or panicky feelings				
Aggression				
Bingeing				
Concentration difficulties				
Crying frequently				
Daydreaming				
Decreased creativity or productivity				
Depressed mood				
Disorganization				
Dissociation				
Distrust of others				
Easily distracted				
Elevated mood				
Excessive worry				
Fatigue				
Fearfulness				
Fire starting				
Food restriction				
Forgetting				
Frequent sadness				
Frustration intolerance				
Gastrointestinal issues (e.g. nausea, vomiting)				
Grief				
Hallucinations				
Headaches				
Hopelessness				
Hostility towards others				
Hyperactivity				
Impulsive actions / speech				
Increased or decreased sex drive				
Increased/decreased appetite				
Indecisiveness				
Irritability				
Loneliness				
Losing train of thought				
Loss of interest in normal activities				

Symptom	None	Mild	Moderate	Severe
Low energy				
Low self-worth				
Memory impairment				
Missing school				
Mood swings				
Nightmares				
Overexercising				
Panic attacks				
Paranoid thoughts				
Personality changes				
Phobias				
Problem solving difficulties				
Problems at home				
Purging food				
Racing thoughts				
Repetitive thoughts				
Repetitive behaviors				
Restlessness				
Self-harming behaviors				
Sensory issues				
Sleep disturbances				
Social anxiety				
Social isolation				
Stealing				
Suicidal thoughts				
Temper tantrums difficult to manage				
Trauma memories				
Unplanned weight gain or loss				
Unresolved guilt				
Violent behaviors				

Does the client use substances (alcohol, marijuana, other drugs)? □ Yes □ No
What kinds? _____ How often? _____
Any problems that have been associated with substance use? _____

How well does the client get along with?
Peers:_____ Adults:_____ Does the client have friends?_____ Keep friends?_____ Understand gestures?_____
Understand jokes? _____ Have a good sense of humor? _____ Understand social cues? _____
Have problems with peer pressure? _____ Get taken advantage of by others? _____
How many friends does the client have? _____ How old are their friends?_____
What does the client like to do for fun?_____
_____
What extracurricular activities is the child involved in? _____

Section 6
MEDICAL HISTORY

Has the client's vision been checked? □ Yes □ No Problems? _____
Has the client's hearing been checked? □ Yes □ No Problems? _____
Does the client have allergies to food or medications? □ No □ Yes: _____
Adverse reactions: _____

Primary care provider/pediatrician: _____ Date of last well child check: _____
Specialists you see (name/type): _____

Previous and current health conditions:

Condition	Dates	Providers	Treatment/Outcomes

Has the client ever had a head injury with loss of consciousness or feeling of being "dazed"? □ Yes □ No

List ***current*** prescription medications:

Medication	Amount	Reason	Prescribed By

List any over-the-counter medications/vitamins/supplements the client regularly takes:
_____

Section 7
EDUCATIONAL HISTORY

Current Grade: _____ School: _____

Does the client have an IEP or 504 Plan: □ No □ Yes, category? _____

Are you willing to provide a copy of the IEP? □ Yes □ No, reason: _____

Placement: □ regular classroom □ resource support □ self-contained classroom □ speech/occupational therapy/ physical therapy □ alternative school setting

Any grades repeated: □ No □ Yes, which grades/reason: _____

Any grades skipped: □ No □ Yes, which grades/reason: _____

Teachers report problems in: □ reading □ spelling □ math □ writing □ attention/concentration □ socialization □ behaviors: _____

Any other academic or school problems? Please explain:_____
_____

Current letter grades: _____

Have teachers reported problems that are not evident at home? If so, what are they?_____
_____

Section 8
INTERVENTION HISTORY

Please list any other providers (prescribers, counselors/therapists, or psychologists) you are currently seeing or have previously seen. Please list the most recent at the top.

Type of Treatment (e.g. medications, therapy, evaluation)	Provider	Dates	Diagnosis/Reason

Would you be willing to sign a release? □ Yes □ No, reason: _____

Are you engaged with any community supports (support groups, social services?) □ No □ Yes:_____
_____