BLUEBIRD
BEHAVIORAL HEALTH

Please complete all information to the best of your ability on this form and return it prior to your first visit. You may need to ask family members about the family history. This will allow for a productive initial visit for us. Information is confidential. Thank you and I look forward to meeting you! *Please bring or arrange for previous records or notes to be sent prior to your appointment.

Child/Adolescent Initial Visit

Child's Name_____ Completed By _____

Sex □ Male □ Female Age _____ Date of Birth _____

Adopted/Custody □ Yes □ No Explain: _____ Place of Birth _____

Parents: □ single □ married □ separated □ divorced □ remarried □ widowed □ cohabitating

If divorced, what are the custody arrangements? _____ *(Please bring copy of custody agreement for the chart)*

Please give other parent's address and phone number _____

Name of Primary Care Provider: _____

Mental Health Provider: _____ Previous Diagnosis (if any): _____

Therapist: _____ How often do you see therapist: _____

(A copy of legal custodianship needs to be provided if child is cared for by person(s) other than living biological or adoptive parents)

Is DHS involved? _____ Are Mental Health services court ordered? _____

Who referred you to our clinic? _____

HOUSEHOLD MEMBERS

Name	Age	Relationship	Occupation/Grade

FAMILY MEMBERS NOT LIVING IN HOUSEHOLD (E.G., STEPCHILDREN, ADULT CHILDREN, ETC.)

Name	Age	Relationship	Occupation/Grade

AREAS OF CONCERN: (check all that apply)

Personal/Social Adjustment

- □ Sad or depressed mood
- □ Withdrawn from family or friends
- □ Loss of interest in activities or hobbies
- □ Feelings of guilt or worthlessness
- □ Feeling hopeless about the future
- □ Sleep disturbance
- □ Change in appetite
- □ Low energy or fatigue
- □ Trouble focusing or concentrating
- □ Thoughts of hurting or killing self
- □ Thoughts of hurting or killing others

- □ Drastic mood swings
- □ Episodes of decreased need for sleep
- □ Extreme hyperactivity
- □ Racing thoughts
- □ Talking so fast it's hard to understand
- □ Overly happy or euphoric
- □ Overly confident

- □ Hearing voices that other people cannot hear
- □ Seeing things other people cannot see
- □ Feeling paranoid
- □ Odd thinking or beliefs

- □ Irritability
- □ Severe angry outbursts (verbal or physical)

- □ Worrying too much
- □ Feeling or acting restless
- □ Muscle tension
- □ Panic or anxiety attacks
- □ Fear of offending others
- □ Any other fears or phobias

- □ Thoughts, feelings or pictures that come into the child's mind even if he/she does not want them to?
- □ Habits the child feels they must do even if he/she knows it does not make sense (for example excessive cleaning, checking, repeating, counting, organizing or hoarding things)?

- □ Poor body image
- □ Trying to lose weight even though he/she is not overweight
- □ Intentionally throwing up after eating

- □ Easily loses temper
- □ Easily annoyed
- □ Defiant
- □ Argues with authority figures
- □ Annoying others on purpose
- □ Blaming others for his/her mistakes
- □ Resentful, spiteful or vindictive
- □ Lying
- □ Stealing
- □ Destroying property
- □ Setting fires
- □ Skipping school
- □ Hurting other people or animals
- □ Difficulty learning
- □ Trouble understanding social cues
- □ Difficulty forming or keeping friendships
- □ Being very sensitive to sound, light, touch or smell
- □ Tics, twitches or involuntary movements
- □ Making involuntary sounds

Usual bedtime is at: _____when in school. _____ when on vacation.

Describe this child/adolescent's sleep pattern or habits:

- □ Sleeps all night without disturbance
- □ Awakens during night/restless sleeper
- □ Gets out of bed in middle of the night
- □ Has trouble falling asleep
- □ Screen time up to bedtime
- □ Sleeps with parent(s)
- □ TV in bedroom
- □ Severe snoring
- □ Early morning awakening
- □ Sleep outside bedroom
- □ Nightmares
- □ Sleepwalking

Describe this child/adolescent's eating habits:

- □ Average
- □ Overeats
- □ Under eats
- □ Binge eating
- □ Intentionally restricts intake
- □ Induces vomiting after eating

HISTORY OF CURRENT PROBLEMS

What are the main concerns that you have about your child? (Include changes in mood, behavior, sleep, eating, free time activities, school concerns). Please use backside of page for important history.

_____
_____
_____

How long have you had these concerns?

_____
_____
_____

What have you already done to address this concern and how effective were these efforts?

_____
_____
_____

Was there an event that caused you to seek treatment now? □ Yes □ No If, yes, please describe.

_____
_____
_____

PAST PSYCHIATRIC HISTORY

Has your child ever had outpatient counseling/therapy?
Individual therapy ___ Family therapy ___ Group therapy ___

Name of Provider	Dates Seen	Reason

Has your child ever seen a psychiatrist/mental health provider for an evaluation/medications?

Name of Provider	Dates Seen	Reason

Has your child ever been admitted/inpatient to a psychiatric hospital?

Name of Hospital	Dates	Reason

OTHER TREATMENT HISTORY	PLACE(S) AND DATE(S)

□ Partial Hospitalization

□ Day Treatment (Alternative School or School-Based)

□ Chemical Dependency Treatment

□ In-home Family Therapy/BHIS Services

□ Psychological Testing (IQ, achievement, etc.)

PAST PSYCHIATRIC HISTORY, CONTINUED

Has your child ever attempted suicide? □ Yes □ No If yes, please describe: _____

_____

Does your child engage in any self-harm behaviors (like cutting)? □ Yes □ No If yes, please describe: _____

_____

Has your child ever been violent or aggressive? □ Yes □ No If yes, please describe: _____

_____

OTHER: Has the child experienced any of the difficulties below? Please check all that apply.

- □ Death of a parent
- □ Death of other loved one/close friend
- □ Separation from parent or family
- □ Parent separation/divorce
- □ Loss of home
- □ Family financial problems
- □ Parent with substance abuse problem
- □ Conflicts with parents
- □ Removal of child from home
- □ Victim of crime or violence
- □ Unwanted pregnancy
- □ School problems
- □ Illness in self
- □ Illness in family (specify) _____
- □ Other: _____ _____

MEDICAL HISTORY

Medications (including over the counter/herbal) child is currently taking:

Medication Name	Dosage	Frequency	Purpose

List any known allergies:_____

Current medical problems:_____

Chronic condition or disability: _____

Any history of seizures, tics, loss of consciousness, or head trauma?_____

_____

Any family history of early or premature cardiac illness or stroke in adults prior to age 50? _____

_____

Prior illnesses or surgeries: _____

Have you ever had an EKG? □ Yes □ No If yes, when _____

Was the EKG □ normal □ abnormal □ unknown

FEMALES ONLY:

Has your child started menstruation? □ Yes □ No If yes, at what age? _____

Are periods regular? □ Yes □ No

Date of last menstrual cycle _____ / _____ / _____

Is there any change in symptom severity with periods? □ Yes □ No

If yes, please describe _____

DEVELOPMENTAL MILESTONES

Gestational age at birth? _____

Complications during pregnancy or delivery? _____

Walking at (months) _____

Saying words at (months) _____

Toilet trained at (months) _____

Please review the following list of medications. If he/she has taken any of these medications, please fill out the specific boxes related to that medication.

Antidepressants	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects? If so, what happened?**
Prozac (fluoxetine)	□			□ Yes □ No	□ Yes □ No
Zoloft (sertraline)	□			□ Yes □ No	□ Yes □ No
Luvox (fluvoxamine)	□			□ Yes □ No	□ Yes □ No
Paxil (paroxetine)	□			□ Yes □ No	□ Yes □ No
Celexa (citalopram)	□			□ Yes □ No	□ Yes □ No
Lexapro (escitalopram)	□			□ Yes □ No	□ Yes □ No
Effexor (venlafaxine)	□			□ Yes □ No	□ Yes □ No
Cymbalta (duloxetine)	□			□ Yes □ No	□ Yes □ No
Wellbutrin (bupropion)	□			□ Yes □ No	□ Yes □ No
Remeron (mirtazapine)	□			□ Yes □ No	□ Yes □ No
Anafranil (clomipramine)	□			□ Yes □ No	□ Yes □ No
Pristiq (desvenlafaxine)	□			□ Yes □ No	□ Yes □ No
Antipsychotics	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects?**
Seroquel (quetiapine)	□			□ Yes □ No	□ Yes □ No
Zyprexa (olanzapine)	□			□ Yes □ No	□ Yes □ No
Geodon (ziprasidone)	□			□ Yes □ No	□ Yes □ No
Abilify (aripiprazole)	□			□ Yes □ No	□ Yes □ No
Clozaril (clozapine)	□			□ Yes □ No	□ Yes □ No
Haldol (haloperidol)	□			□ Yes □ No	□ Yes □ No
Risperdal (risperidone)	□			□ Yes □ No	□ Yes □ No
Lurasidone (latuda)	□			□ Yes □ No	□ Yes □ No
Paliperidone (Invega)	□			□ Yes □ No	□ Yes □ No
Mood Stabilizers	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects?**
Depakote (valproate)	□			□ Yes □ No	□ Yes □ No
Lithium	□			□ Yes □ No	□ Yes □ No
Lamictal (lamotrigine)	□			□ Yes □ No	□ Yes □ No
Tegretol (carbamazepine)	□			□ Yes □ No	□ Yes □ No
Oxcarbamazepine (Trileptal)	□			□ Yes □ No	□ Yes □ No
Sedative/Hypnotics	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects?**
Desyrel (trazodone)	□			□ Yes □ No	□ Yes □ No
Diphenhydramine (Benadryl)	□			□ Yes □ No	□ Yes □ No
Doxylamine (Unisom)	□			□ Yes □ No	□ Yes □ No
Melatonin	□			□ Yes □ No	□ Yes □ No
ADHD Medications	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects?**
Adderall (amphetamine)	□			□ Yes □ No	□ Yes □ No
Concerta (methylphenidate)	□			□ Yes □ No	□ Yes □ No
Ritalin (methylphenidate)	□			□ Yes □ No	□ Yes □ No
Cotempla XR ODT (methylphenidate)	□			□ Yes □ No	□ Yes □ No
Adzenys ER & XR ODT (amphetamine)	□			□ Yes □ No	□ Yes □ No
Strattera (atomoxetine)	□			□ Yes □ No	□ Yes □ No
Clonidine	□			□ Yes □ No	□ Yes □ No
Guanfacine (Tenex)	□			□ Yes □ No	□ Yes □ No
Dexmethylphenidate (Focalin)	□			□ Yes □ No	□ Yes □ No
Vyvance (Lisdexamfetamine)	□			□ Yes □ No	□ Yes □ No
Antianxiety Medications	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects?**
Ativan (lorazepam)	□			□ Yes □ No	□ Yes □ No
Klonopin (clonazepam)	□			□ Yes □ No	□ Yes □ No
Buspar (buspirone)	□			□ Yes □ No	□ Yes □ No
Prazosin (Minipress)	□			□ Yes □ No	□ Yes □ No
Propranolol (Inderal)	□			□ Yes □ No	□ Yes □ No
Other Medications: (specify)	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects?**
	□			□ Yes □ No	□ Yes □ No
	□			□ Yes □ No	□ Yes □ No

SUBSTANCE ABUSE HISTORY

	Last Use	Amount	How often used	How long used
Alcohol				
Marijuana				
Cocaine/Crack				
Inhalants				
LSD				
Prescribed Pills				
Heroin				
Specify Other				
Tobacco				
Caffeine				
Coffee				
Soda		_____cans/oz.		
Energy Drink		_____cans/oz.		

Which of these has your child experienced due to alcohol and/or illegal substance use:
___Blackouts ___Withdrawal Symptoms ___Cravings ___Overdoses ___N/A

LEGAL HISTORY

Has your child ever been arrested? □ Yes □ No
If so, when and why?

_____

_____

What were the charges? _____
Does your child currently have a probation officer? □ Yes □ No
If so, what is their name? _____

_____

FAMILY HISTORY

	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparent
Depression			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal
Anxiety			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal
Panic attacks			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal
Post traumatic stress			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal
OCD			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal
Bipolar Disorder			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal
Schizophrenia			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal
Alcohol problems			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal
Drug problems			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal
ADHD			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal
Suicide attempts/completion			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal
Psychiatric hospital stay			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal
Heart problems			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal
Thyroid problems			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal
Problems with inattention, hyperactivity/impulse control			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal
Problems with aggression, oppositional, or antisocial behavior as a child			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal
Learning disabilities			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal
Cognitive/intellectual disabilities			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal
Autism spectrum			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal
Other: (specify)			□ Maternal □ Paternal	□ Maternal □ Paternal				□ Maternal □ Paternal

LIFE STRESSORS/TRAUMA HISTORY

Has your child been abused: □ Yes □ No

If "yes", please provide the following information using these letters for the Abuse Type:

P = Physical such as beating, slapping, pushing

S = Sexual such as touching, molesting, fondling, exposing, or intercourse

N = Neglect such as failure to feed, shelter, protect, provide medical treatment

Child's Age(s)	Abuse Type	By Whom	Effects on Child	Who did child tell	Results of telling

V = Verbal such as name-calling, shaming, belittling

Traumatic experiences: Has your child ever been exposed to actual or threatened death, serious injury, or sexual violence? □ Yes □ No

If yes, does he/she have any of the following symptoms related to the traumatic event?

- □ Upsetting or intrusive memories
- □ Nightmares
- □ Flashbacks (feeling or acting like the event is happening again)
- □ Avoiding talking or thinking about what happened
- □ Feeling upset by reminders of the event
- □ Having out of body experiences
- □ Feeling like the world/surroundings are not real
- □ Angry outbursts
- □ Recklessness or self-destructive behavior
- □ Getting startled very easily
- □ Always looking around for signs of danger
- □ Trouble remembering some or all of what happened

FAMILY SOCIAL HISTORY

Has this child/adolescent experienced or witnessed any of the following? (check all that apply and explain)

- □ Domestic violence/abuse? _____
- □ Community violence? _____
- □ Serious illness? _____
- □ Serious accident? _____
- □ Divorce/separation/remarriage of parent? _____
- □ Change of residence? _____
- □ Change of schools? _____
- □ Job changes of parents? _____
- □ Pregnancy/miscarriage/abortion? _____
- □ Family chemical abuse? _____
- □ Exposure to drug activity (outside of the home)? _____
- □ Foster care or other out-of-home placement/removal of child from home? _____
  _____
- □ Separation from family or parent? _____
- □ Arrests/imprisonments in family? _____
- □ Death/loss of family member? _____
- □ Death/loss of friend? _____
- □ Family accident or illness? _____
- □ Financial changes or stressors/family financial problems? _____
  _____
- □ Other? _____

SCHOOL HISTORY

Current school _____ **Grade**_____

Name of School	Grades Attended	Grades on Report Card	Reason for Leaving	Detail any successes or failures here

Did your child ever have to repeat any grades? Skipped a grade? _____
Does your child have 5O4 plan or IEP? _____
Is your child in special needs classes? Advanced classes?_____
Describe your child's attitude toward school?_____
Describe your child's behavior in school:
_____
Has your child ever refused to go to school? If "yes", please explain.
_____
_____
Have your child's grades changed over time? If "yes", please explain.
_____
_____
Has your child been tested for learning disabilities or had intellectual testing done? If "yes", please explain the results.
_____
Difficulty making and/or maintaining friendships? _____
Has your child ever been suspended or expelled? Why? When? _____
Does your child bully/get bullied? _____
Involved in organized activities (sports, clubs, religious activities, etc.)? _____
_____

DISCIPLINE

What is your primary disciplinary method with this child? _____
_____
Do both parents view discipline the same way? _____
_____
How does the child respond? _____
_____

MORAL AND SPIRITUAL DEVELOPMENT

What is the spiritual orientation in the child's primary home? _____
_____
How does the child respond? _____
_____

TREATMENT/THERAPY GOALS

What results would you like to see in therapy?

_____
_____
_____

What else is important for me to know? _____
_____
_____
_____
_____
_____

SIGNATURE: _____DATE:_____