Southwestern Behavioral Healthcare, Inc.

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EAP CHILD & ADOLESCENT INFORMATION SHEET

Patient Name_____ DOB: ____/____/_____ Age: _____ M / F (circle one)

Name of person completing this form_____ Relationship_____

What would the patient like to called?_____

Please check any problem areas bothering the patient lately:

- ☐ School or Job issues
- ☐ Family Violence
- ☐ Divorce/Stepfamily issues
- ☐ Poor Concentration
- ☐ Suicide thoughts/attempts
- ☐ Obsessions/Compulsions
- ☐ Eating/Weight
- ☐ Withdrawn/Shy/Few Friends
- ☐ Talking back/Disrespect/Defiance
- ☐ Toileting Problems
- ☐ Relationship/Friend Problems
- ☐ Quick Mood changes
- ☐ Alcohol/Drug Abuse (self)
- ☐ Problems with Parent(s)
- ☐ Cutting/Other Self-injury
- ☐ Health/Pain/Medication problems
- ☐ Hallucinations
- ☐ Gay/Lesbian/Bi/Transgender issues
- ☐ Running away/Legal problems
- ☐ Physical Abuse/Picked on/Bullied
- ☐ Depression
- ☐ Fears/Anxiety/Panic Attacks
- ☐ Brother/Sister issues
- ☐ Sleep Problems/Tired
- ☐ Self-Esteem
- ☐ Forgets/Doesn't do Chores or Hygiene
- ☐ Hyperactive/Impulsive
- ☐ Not enough Family Time
- ☐ Anger/Temper/Outbursts
- ☐ Sexual Abuse/Date Rape
- ☐ Alcohol/Drug Abuse (other)
- ☐ Death of a loved one/Other losses
- ☐ Harm to others
- ☐ Legal Problems
- ☐ Sexual Problems
- ☐ Other_____

What are the patient's goals for evaluation/treatment?_____

What are your goals for the patient's evaluation/treatment?_____

Current Family Information:

Father's name_____ Age_____ Occupation_____

Mother's name_____ Age_____ Occupation_____

Are parents married? Yes / No *(circle one)* Separated? Yes / No *(circle one)* Divorced? Yes / No *(circle one)*
If parents are no longer together, custody papers must be provided before treatment can begin.

Is your child adopted? Yes / No *(circle one)* If yes, age when adopted_____

Who is living in the home, besides parent(s) and patient?

Family Member (Names)	Relationship	Mental Health or Substance Abuse Issue	Current Relationship (excellent, fair, etc.)

Education/Work History:
Child's School:_____ Grade:_____

Does your child have an IEP or 504 Plan? Yes / No *(circle one)* If yes, describe_____

_____

Has your child ever been diagnosed with: *(check all those that apply)*
Learning Disability_____ ADHD_____ MR_____ Emotional Disturbance_____

Describe emotional and behavioral issues at school_____

_____

Describe any learning/educational issues in the family_____

_____

Legal History:
Past/current legal issues the patient has been involved in:_____

Mental Health History:
Has your child EVER: _____Made a suicide attempt _____Hurt themself on purpose _____Overdosed, on purpose or accident
Has your child ever participated in **inpatient** (overnight) psychiatric treatment? Yes / No *(circle one)*

What mental health conditions was your child treated for?_____

Where	Child's Age	Reason	Length of Stay

Has your child ever participated in outpatient (at an office) psychiatric treatment? Yes / No *(circle one)*

What mental health conditions was the patient treated for?_____

Is your child currently in mental health treatment with anyone else? Yes / No *(circle one)* If yes, please complete below:

Where	Child's Age	Reason	Length of Treatment

Has your child ever been prescribed mental health medications before? Yes / No *(circle one)* If yes, please complete below:

Medication	Date	Dose	Reason	Effective	Prescriber	Side Effects
				Yes No		
				Yes No		
				Yes No		

Please describe any history or current mental health conditions in the family_____

_____

Medical History:
Patient's Primary Care Physician:_____

Rate the patient's overall health: Excellent Good Poor Very Poor *(circle one)*

List any serious medical conditions, surgeries, head injuries, hospitalizations, or accidents the patient has had and at what age:_____

Is your child currently experiencing chronic or acute pain? If so, describe_____

Please describe any history of or current medical conditions in the family:_____

_____

Is your child currently in treatment for any medical conditions? Yes / No If yes, please complete below:

Condition	Physician	Medications

Does your child have any food or drug allergies? Yes / No (circle one) If yes, please complete below:

Allergen	Severity	Symptoms/Reaction
	Mild Moderate Severe	
	Mild Moderate Severe	
	Mild Moderate Severe	
	Mild Moderate Severe	

Substance Use History: (Complete if patient is 12 years or older, or if this is a concern)

Does the patient use any alcohol or drugs? Yes / No Does the patient smoke cigarettes? Yes / No

If yes, how many drinks per day_____ If yes, how many per day_____ cigarettes OR packs *(circle one)*

List any negative consequences from substance use (i.e. lowered grades, school problems, legal problems, etc.):_____

_____

Please complete for the patient:

Substance	Frequency	Age of First Use	Last Used

List any previous substance abuse treatment for patient:

Where	When	Type (inpatient, outpatient, group)	Effective
			Yes / No
			Yes / No

Sleep:

To bed at _____am/pm Up from bed at _____am/pm

TV/computer/cell phone hours daily_____ Average hours sleep per night last week_____

Hours per night you need to feel rested and alert_____

- ☐ Can't get to sleep
- ☐ Wake up too early
- ☐ Sleep walking
- ☐ Wake up frequently
- ☐ Oversleep
- ☐ Snore/Stop breathing while sleeping
- ☐ Hard to return to sleep
- ☐ Wake up tired
- ☐ Nightmares *How many time per week*_____
- ☐ Naps *How many per day*_____

Appetite:

- ☐ Good ☐ Fair ☐ Poor
- ☐ Healthy/nutritious food ☐ Lots of junk food

Caffeine:
Servings per day: _____Coffee _____Caffeinated sodas _____ Power/energy drinks _____Pills

Current Functioning:
What are the patient's interests, hobbies, and extra-curricular activities?_____

What are the patient's strengths?_____

What are the patient's difficulties?_____

What other things about the patient's life would it be important for us to know?_____

_____

Please also provide copies of any documents (i.e. school reports, previous evaluations, IEPs, legal papers, consents, etc.) that would be help us get to know your child better. We look forward to meeting with you!

The Staff at Southwestern Behavioral Healthcare, Inc.