Youth – Confidential Health History — Parent/Guardian Form

turning point
A SYSTEM OF CARE

Youth's Full Name: DOB: Today's Date:

Street Address: City/State: Zip:

Youth's SSN:_____ Phone: _____

Email: _____ Age: _____

Youth's Preferred Name: _____

Mother's Name: _____

Father's Name: _____

Members in Household:

Is youth in foster care? __ Yes __No
Foster Parent Name: _____
Case Manager Name: _____

Family Financial Support: ___ Food Stamps ___TANF

First Language: ___English ___Spanish ___Other: _____
English Fluent? __ Yes __No
Race:

- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ American Indian
- ☐ Asian
- ☐ Other: _____

Ethnicity:

- ☐ Not Hispanic/Not Latino
- ☐ Other Hispanic, Latino of Central/South America
- ☐ Latino unknown origin
- ☐ Puerto Rican
- ☐ Mexican
- ☐ Cuban

Probation Involvement? ◯ Yes ◯ No

Employed? ◯ Yes ◯ No

Biological Sex:

- ☐ Male
- ☐ Female

Gender Identity:

- ☐ Male
- ☐ Female
- ☐ Transgender Male (Female-to-Male)
- ☐ Transgender Female (Male-to-Female)
- ☐ Gender non-conforming
- ☐ Choose not to disclose
- ☐ Other: _____

Sexual Orientation:

- ☐ Lesbian, gay, homosexual
- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Don't know
- ☐ Choose not to disclose
- ☐ Other: _____

Impairments/Disabilities:

- ☐ Learning or Reading Disability
- ☐ Communication Difficulties
- ☐ Developmental Disabilities
- ☐ Hard of Hearing
- ☐ Deaf
- ☐ Blind
- ☐ Non-ambulatory
- ☐ Traumatic Brain Injury
- ☐ Other:_____

Tobacco/Smoking Habits:

- ☐ Never
- ☐ Light everyday
- ☐ Everyday
- ☐ Heavy everyday
- ☐ Smokeless Tobacco (Vape, Chew, E-Cigs)
- ☐ Former smoker

Home Status:

- ☐ Permanent Housing
- ☐ Temporarily living with others
- ☐ Homeless
- ☐ Public shelter
- ☐ Institutional Housing
- ☐ Transitional Housing
- ☐ Other:_____

How long has your youth lived in your current housing situation?

- ☐ Less than 6 months
- ☐ 6 months -1 year
- ☐ 1-2 years
- ☐ 2+ years

Are there any cultural, ethnic, or religious/spiritual issues the your therapist should be aware of? __ Yes __No

Does your youth have a shared religious/spiritual community?
__ Yes __No

Do your youth have supportive social supports/circle of friends?
__ Yes __No

DEVELOPMENTAL MILESTONES HISTORY:
Was the pregnancy and delivery of your child normal? ◯ Yes ◯ No
Did your child walk across the room alone by 18 months? ◯ Yes ◯ No
Does your child do age appropriate chores regularly? ◯ Yes ◯ No
Does your child maintain friendships with youth of the same age easily? ◯ Yes ◯ No

Name of School: _____ Strengths:

School Performance:
___Strong ___Fair ___Needs Improvement Hobbies:

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FOR YOUTH AGES 6-17				
Over the past 2 weeks, how often has your youth experienced the following?	None	Some Days	Most Days	Everyday
Little interest/pleasure in doing things				
Seemed sad or depressed for several hours				
Feeling down/depressed/hopeless				
Trouble sleeping too little or too much				
Feeling tired/not having enough energy				
Poor appetite or overeating				
Feeling bad about him/herself				
Seemed more irritated or easily annoyed than usual				
Trouble concentrating or paying attention in school or other activities				
Engaging in more risky behaviors/activities than usual				
Moving/speaking slower, or being fidgety/restless				
Wanting to be dead				
Wanting to hurt others				
Feeling nervous, anxious or scared				
Not be able to stop worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it is hard to sit still				
Seemed angry and lost their temper				
Talked about hearing voices or seeing visions that no one else sees/hears				
Felt the need to repeatedly check on certain things				
Had to do things in a certain way to prevent bad things from happening				

In the past 2 weeks, has your youth…			
Had an alcoholic beverage	Yes	No	Don't Know
Smoked a cigarette, vaped, etc.			
Used drugs like marijuana, cocaine, methamphetamine, etc.			
Used any medications without prescription (e.g. Ritalin, Adderall)			
Tried to kill him/herself?			

Youth Substance Use History: NA: ◯	How Much:	How Often:	Age of First Use:	Last Use:
◯ Alcohol				
◯ Marijuana				
◯ Methamphetamine				
◯ Crack/Cocaine				
◯ Opiates/Heroin				
◯ Other:				

Does anyone in your family currently have difficulty with alcohol or other drugs?	◯ Yes	◯ No
Have your youth ever used drugs using an IV needle?	◯ Yes	◯ No

History of Youth Substance Use Problems (past 12 months; check any that apply):			
◯ Failed attempts to stop use	◯ Guilt due to excessive use	◯ Criticism by others	◯ Physical injury
◯ Memory blackouts	◯ Perceptual Disturbance	◯ Legal Problems	◯ Missed school
◯ Arguments or fights	◯ loss of consciousness	◯ Hallucinations	◯ Incarceration
◯ Medical problems	◯ Shared needle use	◯ Tremors	◯ Seizures
◯ Problems with family/friends	◯ Problems with home responsibilities	◯ Financial problems	

Abuse/Trauma History: ◯ NA					
Current Abuse:	☐NA	☐ Physical	☐ Emotional	☐ Exploitation	☐Sexual	☐ Neglect
Past Abuse:	☐ NA	☐ Physical	☐ Emotional	☐ Exploitation	☐ Sexual	☐ Neglect

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Health & Life Factors Screen:
Pain Screen: Is your youth currently having physical pain or discomfort? ◯ Yes ◯ No If yes, pain location? _____
Pain Rating (0=no pain, 10=worst ever): _____
Is the pain currently being treated? Yes ◯ No If yes, treatment provider: _____

Tuberculosis Screen: Please check any of the following symptoms your youth may be experiencing:
Chest Pain [ ] Night sweats [ ] Coughing up blood [ ] Persistent Cough [ ] Fever/chills [ ]
Have you ever been told you may have Tuberculosis? ◯ Yes ◯ No
Have you received treatment for TB? ◯ Yes ◯ No

Nutrition Screen:
Does your youth have any nutrition concerns? ◯ Y ◯ N
If yes, please describe:

MEDICAL INFORMATION:

Youth's Current Medications	Dose	Frequency	Why Prescribed	Prescription Provider

Medication/Vaccine Allergies	Reaction (rash, shock, hives, etc.)

Does your youth have a primary care provider (Family Medicine, Internal Medicine, or Pediatrician)?

Name of primary care provider: _____ Phone: _____

Height:

Weight:

Has your youth had the following examinations in the past year:
Physical Exam: ◯ Yes ◯ No Visual Exam: ◯ Yes ◯ No Hearing Exam: ◯ Yes ◯ No

Name of doctor: _____ Year of last physical exam:_____ Doctor's phone #: _____
Name of dentist:_____ Year of last dental exam:_____Dentist's phone #: _____

Family Medical History:	Self	Mother's Side	Father's Side	Comments
ADD/ADHD				
Anxiety Disorder				
Autism Spectrum Disorder				
Brain Injury / Stroke / TIA				
Depression / Bipolar Disorder				
Developmental Delay/Learning Disability				
Diabetes				
Ear or Hearing Problems				
Eating Disorder				
Headaches / Migraines				
Heart Disease/Heart Problems				
Kidney Disease				
Liver Disease/Cirrhosis				
Lung Disease				
Schizophrenia				
Substance Use Disorder				
Vision Problems				

Youth Health Habits:

Sexual Activity
Sexually Active: ◯ Yes ◯ No If yes, condom used? : ◯ Yes ◯ No If yes, pregnant? : ◯ Yes ◯ No

Exercise
◯ 3x per week ◯ active 1-2x per week ◯ sedentary (very little to no regular activity)

Activities engaged in: _____ Barriers to activity: _____