Youth – Confidential Health History — Self Report Form

Full Name: DOB: Today's Date:

Street Address: City/State: Zip:

SSN:________________ Phone: ____________

Email: ___________________________ Age: _____

Your Preferred Name: _____________________________

Mother's Name: ___________________________________

Father's Name: ___________________________________

Members in Household:

Are you 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 have you 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

Do you have a shared religious/spiritual community? __ Yes __No

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

DEVELOPMENTAL MILESTONES HISTORY:

Was your pregnancy and delivery normal? ◯ Yes ◯ No

Did you walk across the room alone by 18 months? ◯ Yes ◯ No

Do you do age-appropriate chores regularly? ◯ Yes ◯ No

Does you 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 have you 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, have you…			
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?			

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 you ever used drugs using an IV needle?	◯ Yes	◯ No

History of 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: Are you 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 you 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:

Do you have any nutrition concerns?

◯ Y ◯ N

If yes, please describe:

MEDICAL INFORMATION:

Current Medications	Dose	Frequency	Why Prescribed	Prescription Provider

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

Do you have a primary care provider (Family Medicine, Internal Medicine, or Pediatrician)?

Name of primary care provider: ________________________________ Phone: ________________

Height:

Weight:

Have you 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				

Health Habits:

<u>Sexual Activity</u>

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

<u>Exercise</u>

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

Activities engaged in: ______________________________________ Barriers to activity: ______________________________