Welcome to Bear River Mental Health Services, Inc. As an important part of your assessment appointment, we ask you to fill out the following information packet. Completion of this packet will help us determine the best treatment program we can offer, and it will also help your therapist become better acquainted with you. This information is kept confidential, except for special legal cases. No one outside of the Center may see your records without your written permission. If you have questions or concerns, please contact our service coordination staff at:

435-752-0750 in Cache or Rich County

435-734-9449 in Brigham City

435-257-2168 in the Tremonton area.

PERSONAL HISTORY
(Youth Form)

Youth's Legal Name _____ Age _____ Today's Date _____

Youth's Preferred Name _____ Youth's Preferred Pronoun _____

Completed by _____ Relationship to Youth _____

Note: Please feel free to discuss any questions you have when you review this form with the clinician.

PRESENTING PROBLEMS

Please list the problem or problems for which you are seeking help. Begin with the most difficult problem first.

1. _____

   Rate the severity of problem #1: ○ mild ○ moderate ○ severe

2. _____

   Rate the severity of problem #2: ○ mild ○ moderate ○ severe

History of this/these problems_____

_____

ATTEMPTED SOLUTIONS

What solutions have already been tried to correct the presenting problems? _____

_____

_____

_____

GOALS

What are your hopes/goals for this youth to accomplish in treatment (please be specific)?

1. _____
2. _____
3. _____

SUBSTANCE USE (if applicable)

Has youth ever used the following substances:

		Frequency of use	Length of use (when started)
❑	Cigarettes/Tobacco	_____	_____
❑	Alcohol	_____	_____
❑	Marijuana	_____	_____
❑	Stimulants	_____	_____
❑	Pain pills/Muscle relaxers	_____	_____
❑	Other _____	_____	_____

Has youth ever received treatment for substance abuse? ○ No ○ Yes

From whom/when: _____

MEDICAL INFORMATION AND HISTORY

Who is youth's family doctor? _____ Phone #: _____

Please list and date any major illness, injury, surgery, and/or hospitalization this youth has had:

_____ Date _____

_____ Date _____

_____ Date _____

List any allergies youth has: _____

Date of last physical exam: _____ Date of last dental exam: _____

Immunizations are up to date. ○ No ○ Yes

Youth is sexually active. ○ No ○ Yes ○ Unknown

Is (female) youth pregnant? ○ No ○ Yes Due date: _____

Please check all of the following medical conditions which youth now has or has had in the past:

❑	Stomach/Bowel problems	❑	Hyperactivity	❑	High or low energy level
❑	Severe headaches	❑	Sleep problems	❑	Diabetes
❑	Convulsions/Seizures	❑	Weight gain/loss	❑	Hypoglycemia
❑	Cancer	❑	Appetite problems	❑	Other _____

Has youth been tested for:	TB	○ No	○ Yes	○ Positive	○ Negative
	Hepatitis	○ No	○ Yes	○ Positive	○ Negative
	HIV	○ No	○ Yes	○ Positive	○ Negative

List *any* current medications youth is now taking and dosage:

Medication	Dosage	Prescribing Doctor
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any mental health medications youth has taken in the past:

Medication	Dosage	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

FUNCTIONING

Are there any concerns for this youth about:

❑ Language functioning (speech and hearing): explain _____

❑ Visual functioning: explain _____

❑ Intellectual functioning: explain _____

❑ Learning ability: explain _____

EARLY CHILDHOOD DEVELOPMENT

When your child was a *toddler* (***1 ½ to 3 years old***):

1. Did your child take an interest in other children? ○ No ○ Yes
2. Did your child ever use his/her index finger to point, to indicate interest in something? ○ No ○ Yes
3. Did your child ever bring objects over to you to show you something? ○ No ○ Yes
4. Did your child imitate you? (e.g., you make a face – will they imitate it?)? ○ No ○ Yes
5. Did you child respond to his/her name when you call? ○ No ○ Yes
6. If you pointed at a toy across the room, did your child look at it? ○ No ○ Yes

Pregnancy and Delivery Information:

- ❑ Mother did not receive prenatal care
- ❑ Any issues or problems during pregnancy: explain _____
- ❑ Prenatal exposure to substances
- ❑ Medications taken by mother during pregnancy: List: _____
- ❑ Any issues with delivery: _____

From age 2-5 youth showed:

- ❑ A short interest or attention span
- ❑ Restlessness
- ❑ Frequent temper outbursts
- ❑ Destructive with toys
- ❑ Generally unhappy or irritable
- ❑ Intense reactions, whether positive or negative
- ❑ Inability to adapt to new situations
- ❑ Overly cautious or slow to trust
- ❑ Too quick to trust
- ❑ Rarely sought comfort
- ❑ Rarely involved in other's play
- ❑ Tuned out/loses contact

Please write how old the youth was when they first:

Walked alone _____ Was toilet-trained _____ Knew colors _____

Spoke single words _____ Spoke sentences _____ Listen to a 10 min story _____

Please describe the initial relationship between the parent(s) and this youth? _____
_____

CURRENT LIVING ARRANGEMENTS (Who does the child live with?)

Please list all family members and indicate whether they're living in the home. Please include non-family members who currently live in the home.

Current Living Arrangements				
Name	Age	Relationship to Youth	Living in the home	Occupation or School Grade
			○ No ○ Yes	
			○ No ○ Yes	
			○ No ○ Yes	
			○ No ○ Yes	
			○ No ○ Yes	

FAMILY and CULTURAL HISTORY

Biological parents are: ○ Married ○ Unmarried ○ Separated ○ Divorced ○ One or both are deceased

Was youth adopted? ○ No ○ Yes At what age? _____ From where? _____

Who has legal custody of youth? _____

Please list any separations from your parents / care givers you may have experienced as a child (ie. placed in foster care, moved from family member to family member, incarceration of parent, death of a parent etc.): _____

_____

Please list any residential changes for this youth in the last 5 years _____

_____

_____

Religious Preference (optional): _____

Please list (describe) any information that is unique about this youth or his/her family that would be helpful for the therapist to be aware of, i.e. religious views/beliefs, family heritage, family traditions, cultural beliefs:

_____

_____

_____

_____

_____

ABUSE and TRAUMA HISTORY

Has this youth ever experienced any kind of abuse?

Emotional abuse ○ No ○ Yes If yes, by whom? _____

Physical abuse ○ No ○ Yes If yes, by whom? _____

Sexual abuse ○ No ○ Yes If yes, by whom? _____

Has youth ever been involved in any other type of traumatic incidents such as Medical Trauma, Natural Disasters, Refugee Trauma, School Violence, Terrorism, or Traumatic Grief? ○ No ○ Yes

Explain: _____

CHILD'S MENTAL HEALTH TREATMENT HISTORY

1. Has youth ever received previous mental health counseling or treatment? ○ No ○ Yes

   Therapist _____ When _____

   Regarding _____

   Therapist _____ When _____

   Regarding _____

2. Has youth ever been hospitalized for mental health reasons? ○ No ○ Yes

Where _____ When _____

Where _____ When _____

FAMILY PSYCHIATRIC HISTORY

Please list any blood relations (e.g., parents, grandparents, aunts, uncles, siblings, etc.) who have had:

Mental or nervous breakdown _____

Depression _____

Anxiety or severe nervousness _____

Alcoholism _____

Drug abuse _____

Mood swings _____

Strange behavior _____

Extreme temper problems _____

Suicide attempt or successful suicide _____

Extremely shy, quiet-isolated from others _____

Mental health hospitalization _____

Childhood learning or reading difficulty _____

Serious behavior difficulties in childhood _____

Serious marital disagreements or discipline of children _____

History of parental separation or divorce _____

Significant medical illness (list relative and illness) _____

Is anyone in youth's family receiving mental health services at this time? ○ No ○ Yes

If so, list relationship and where: _____

_____

EDUCATION HISTORY

What school is youth attending? _____

Current Grade level (please circle): Preschool Kindergarten

1 2 3 4 5 6 7 8 9 10 11 12

Please check all that apply.

- ❑ Autistically Impaired
- ❑ Learning disabilities
- ❑ Emotional problems
- ❑ Resource classes
- ❑ Has IEP
- ❑ School behavior problems

Grade Point Average (if applicable): _____

Math is: ○ strong ○ average ○ weak

Reading is: ○ strong ○ average ○ weak

Strongest subject: _____

Weakest subject: _____

Does the youth have a job? ○ No ○ Yes Describe: _____

SOCIAL HISTORY

Mark number of friends youth has: ○ More than 10 ○ 10 - 3 ○ 2 - 1 ○ None

Peers are a positive influence: ○ No ○ Yes

Difficulties with friends/peers: _____

LEGAL PROBLEMS

Has the youth ever been in trouble with the law or convicted of a crime: ○ No ○ Yes

Is the youth on probation: ○ No ○ Yes

OTHER AGENCY INVOLVEMENT

Check agencies in which youth or family is currently involved, or has been in the past.

- ❑ Department of Child & Family Services
- ❑ Juvenile Court
- ❑ Adolescent Probation
- ❑ Health Department – Substance Abuse
- ❑ Youth Corrections
- ❑ Special School Services
- ❑ Department of Services for People with Disabilities
- ❑ Center for Persons with Disabilities
- ❑ Other Agency

SAFETY, PROTECTION AND RISK ASSESSMENT

1. Is youth thinking about or planning suicide or harming themselves now? ○ No ○ Yes

   If yes, please explain: _____

   _____

2. Has youth ever attempted suicide or to harm themselves in any way? ○ No ○ Yes

   If yes, please explain: _____

   _____

3. Has youth physically or sexually assaulted someone else? ○ No ○ Yes

   If yes, please explain: _____

   _____

STRENGTHS

Please list youth's positive strengths and/or best ways to cope: _____

_____

_____

_____

_____

_____

CURRENT AND PAST SYMPTOMS Please rate the following symptoms for this youth:

	Never	Almost Never	Some of the time	Most of the time	Almost all the time
Short attention span	○	○	○	○	○
Impulsiveness problems	○	○	○	○	○
Concentration problems	○	○	○	○	○
Difficulty with change	○	○	○	○	○
Irritable	○	○	○	○	○
Aggressive to people or animals	○	○	○	○	○
Destruction of property	○	○	○	○	○
Lying	○	○	○	○	○
Explosive anger	○	○	○	○	○
Breaking Rules	○	○	○	○	○
Depression	○	○	○	○	○
Mood swings	○	○	○	○	○
Low self esteem	○	○	○	○	○
Guilt	○	○	○	○	○
Anxiety and Stress	○	○	○	○	○
Separation anxiety	○	○	○	○	○
Problems sleeping	○	○	○	○	○
Nightmares	○	○	○	○	○
Bed wetting / Day accidents	○	○	○	○	○
Other, please list: _____	○	○	○	○	○

Additional Information:

_____

_____

_____

_____

_____

_____ _____

Parent/Guardian Signature Date