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 Name ________________________________ Age _____________ Today's Date ___________________

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
- ❑ Severe headaches
- ❑ Convulsions/Seizures
- ❑ Cancer
- ❑ Hyperactivity
- ❑ Sleep problems
- ❑ Weight gain/loss
- ❑ Appetite problems
- ❑ High or low energy level
- ❑ Diabetes
- ❑ Hypoglycemia
- ❑ 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.

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

**FAMILY/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:

_____________________________________________________________________________________________

_____________________________________________________________________________________________

**ABUSE / 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 | ○ | ○ | ○ | ○ | ○ |

Additional Information:

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

Parent/Guardian Signature ______________________ Date ______________