



I have enclosed the application for admission to our Inpatient Program. In this envelope you will find the following documents that must be returned before we can make a determination.

- Client Face Sheet, page 2
- Medical History, page 3 and 4
- Symptom Checklist, page 5 and 6
- Social History, page 7 and 8
- Social History Part II: Life Events Checklist, page 9

You will also find a blank Consents to Release and Exchange Information allowing current or past providers to share information about the child. Refer to the sample ROI that has also been provided for instructions on completing.

Note: *If the child receives multiple services and sees multiple providers at the same agency then you only need 1 release for that agency. However, if the child sees multiple providers at different agencies then a release needs to be filled out for each agency that the child receives services at.*

The following consents will need returned, if not applicable please indicate such in the table below:

Med Manager/Psychiatrist	<input type="checkbox"/> Consent Completed	<input type="checkbox"/> Not applicable
Psychologist/Psychological Testing	<input type="checkbox"/> Consent Completed	<input type="checkbox"/> Not applicable
Therapist	<input type="checkbox"/> Consent Completed	<input type="checkbox"/> Not applicable
Group Therapy [DBT, Life Program, Intensive Outpatient]	<input type="checkbox"/> Consent Completed	<input type="checkbox"/> Not applicable
BHIS	<input type="checkbox"/> Consent Completed	<input type="checkbox"/> Not applicable
PIH/IHH	<input type="checkbox"/> Consent Completed	<input type="checkbox"/> Not applicable
Hospital	<input type="checkbox"/> Consent Completed	<input type="checkbox"/> Not applicable
DHS	<input type="checkbox"/> Consent Completed	<input type="checkbox"/> Not applicable
JCS	<input type="checkbox"/> Consent Completed	<input type="checkbox"/> Not applicable
Attorney or GAL	<input type="checkbox"/> Consent Completed	<input type="checkbox"/> Not applicable
School	<input type="checkbox"/> Consent Completed	<input type="checkbox"/> Not applicable
MCO Case Manager	<input type="checkbox"/> Consent Completed	<input type="checkbox"/> Not applicable
Other:	<input type="checkbox"/> Consent Completed	<input type="checkbox"/> Not applicable

If you have records already, please include them when returning your admission packet. You may give the forms to providers who can fax or mail information to the Admissions Office. You may also return everything to the Admissions Office for processing.

We will be in contact with you after records have been received and reviewed by our clinical team. At this point we will determine if our program is appropriate for the child or we will make recommendations for other services.

Additional information can be found on our website at www.tanagerplace.org. Please feel free to contact me with any questions.

Sincerely,

Jenn Hodgden
 Inpatient Authorization Coordinator
 Ph: 319-365-9165 x330
jhodgden@tanagerplace.org

CLIENT FACE SHEET



Client Information

First Name: _____ **MI:** _____ **Last Name:** _____
Address: _____
(Street) (City) (State) (Zip) (County)
Home Phone: (_____) _____ **Cell Phone:** (_____) _____ **Work Phone:** (_____) _____
Email Address (Parent/Guardian): _____
Client's Date of Birth: _____ **Gender:** Male Female
Height: _____ **Weight:** _____ **Hair-color:** _____
Race: White African American Asian Bi-Racial Hispanic Native American Pacific Islander African

Caregiver/Emergency Contact Information

is legal Guardian

Name: _____ **Relationship to Client:** _____ Same Info. Above
Address: _____
(Street) (City) (State) (Zip) (County)
Home Phone: (_____) _____ **Cell Phone:** (_____) _____ **Email:** _____

Individual Financially Responsible for Account

is legal Guardian

Name: _____ **Relationship to Client:** _____ Same Info. Above
Address: _____
(Street) (City) (State) (Zip) (County)
Home Phone: (_____) _____ **Cell Phone:** (_____) _____ **Email:** _____

Does the child receive any of the following insurance coverage or benefits?

IME Iowa Total Care Amerigroup Other:

Policy ID: _____

Primary Commercial/Private Insurance

Insurance Company: _____

Insurance ID: _____ Group# _____

Relationship to Insured: Child Spouse Self Other

Subscriber information:

Name: _____

DOB: _____ Gender: Male Female

Address: _____

Phone #: (_____) _____

Employer: _____

Secondary (if applicable)

Insurance Company: _____

Insurance ID: _____ Group# _____

Relationship to Insured: Child Spouse Self Other

Subscriber information:

Name: _____

DOB: _____ Gender: Male Female

Address: _____

Phone #: (_____) _____

Employer: _____

Additional Benefit Information

Social Security Benefits

\$ amount per month: _____

Child Support

\$ amount per month: _____

Adoption Subsidy

\$ amount per month: _____

If your child receives income, you will be required to pay some or all of these amounts towards the cost of your child's care.

MEDICAL HISTORY



First Name: _____ MI: _____ Last Name: _____ DOB: _____

Allergies No known Allergies List drugs, food, latex, other and reaction: _____

Immunizations up to date? Yes No If no, explain: _____

Has your child had a history of, or any problems, with any of the following:

Seizures/Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle/Bone/Joint Issues	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tremors	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nosebleeds	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ear Tubes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
- Use inhaler?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing impaired	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	- Use hearing aids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Menstruation Issues	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Current pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sexually Transmitted Diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV/AIDs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer or Radiation treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Constipation/Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	MRSA	<input type="checkbox"/> Yes	<input type="checkbox"/> No
GERD/Acid Reflux	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eating Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Meningitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Urinary Tract Infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis or Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skin Issues [Eczema, Psoriasis, etc.]	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes to any above explain:

Speech Therapy, Occupational Therapy, Physical Therapy? Yes No

Physical limitations that impact ability to bathe or toilet independently? If yes, explain: _____ Yes No

Special Dietary Accommodations? Yes No

Hygiene: Poor Fair Good

Any recent diagnostic testing [EKG, Ultrasound, Lab, x-ray]? Yes No

Any other medical history not listed above: _____

Family Medical History [please indicate below family history of, or problems, with the following]

	Mother	Father	Aunt	Uncle	Grandmother	Grandfather	Sibling
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic/Inheritable Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:							

Surgical History/Hospitalization:

Date	Reason/Type	Comment

Medication bottles or prescriptions from medication provider have been provided to admissions?

 Yes No**Medical Providers****Primary Care Physician [PCP]** no current

Name: _____ Office Name: _____

Address: _____
(Street) (City) (State) (Zip) (County)

Phone #: (_____) _____ Date of last visit: _____ Next Appointment: _____

Dentist no current

Name: _____ Office Name: _____

Address: _____
(Street) (City) (State) (Zip) (County)

Phone #: (_____) _____ Date of last visit: _____ Next Appointment: _____

Has antibiotic medicine been required before dental treatment?

 Yes No

Current toothache, sores, or swelling in the mouth?

 Yes No

Other dental problems?

 Yes No

Requires help with tooth brushing?

 Yes No

Thumb, finger, or pacifier sucking?

 Yes No

If yes, please explain: _____

Orthodontist / Clinic no current

Name: _____ Office Name: _____

Address: _____
(Street) (City) (State) (Zip) (County)

Phone #: (_____) _____ Date of last visit: _____ Next Appointment: _____

Please explain condition and treatment provided: _____

Vision [optometrist] no current

Name: _____ Office Name: _____

Address: _____
(Street) (City) (State) (Zip) (County)

Phone #: (_____) _____ Date of last visit: _____ Next Appointment: _____

Does the child have glasses or contacts?

 Yes No

If yes, how often are they worn? _____

Are glasses/contacts with the child here?

 Yes No**Other [PT/OT/Speech]** no current

Name: _____ Office Name: _____

Address: _____
(Street) (City) (State) (Zip) (County)

Phone #: (_____) _____ Date of last visit: _____ Next Appointment: _____

SYMPTOM CHECKLIST



Client Name: _____ MI: _____ Last Name: _____ DOB: _____

INSTRUCTIONS: *INDICATE PRESENCE OF EACH PROBLEM OR SYMPTOM, WITH LEVEL OF OCCURRENCES FROM NEVER TO ALWAYS*

	Never	Rarely	Sometimes	Often	Always
Physical Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Verbal Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Destruction of property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Argues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fights with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quick to anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meltdowns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoidant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cruelty towards animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-compliant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runs away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Absent from school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Takes unnecessary risks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexualized behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regressive Behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty coping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indiscriminate affection with strangers and others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clingy with parent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with parental absence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does not go to parent for comfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Will not accept closeness or comfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acute jealousy towards siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bossy toward others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teases others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is down on him or herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acts younger than children his or her age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does not show feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does not understand other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blames others for his or her troubles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties with peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent visits to the Dr.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashbacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body image distortion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Negative Self Talk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Negative view of self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutritional concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oversleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Continued...	Never	Rarely	Sometimes	Often	Always
Lack of sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hoarding behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afraid of new situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive fears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Racing Thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reactive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rigidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tense	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worries excessively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentration problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fails to complete tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fidgety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low frustration tolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impulsive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Procrastinates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crying Spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged sadness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Isolated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of interest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Complains of aches and pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tires easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandiose thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paranoia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enuresis (wetting accidents)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Encopresis (soiling accidents)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other abnormal bathroom behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Pill Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nicotine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Technology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non Suicidal Self Injury [NSSI]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homicidal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY

Client Name: _____ MI: _____ Last Name: _____ DOB: _____

I. CLIENT INFORMATION

Mental Health History

Service History:	
Diagnosis History:	
Hospitalization History:	
Medication History:	
Current Medication/ Prescriber:	

Physical/Medical History

Current Issues:	
Past Issues:	
Surgeries:	
Known Allergies:	
Current Treating Physician:	

EARLY CHILDHOOD/ DEVELOPMENTAL HISTORY	YES	NO	COMMENTS
Did client's mother receive proper prenatal care?	<input type="checkbox"/>	<input type="checkbox"/>	
Was the client exposed to substances in utero?	<input type="checkbox"/>	<input type="checkbox"/>	
Were there complications during pregnancy or with client's birth?	<input type="checkbox"/>	<input type="checkbox"/>	
Did client or caregiver require special attention in first few weeks or months of life?	<input type="checkbox"/>	<input type="checkbox"/>	
Were developmental milestones met within normal time span?	<input type="checkbox"/>	<input type="checkbox"/>	
<i>In the first 5 years of life:</i>			
As a baby, was your client difficult to sooth or comfort?	<input type="checkbox"/>	<input type="checkbox"/>	
Did your client have frequent, intense temper tantrums or mood changes?	<input type="checkbox"/>	<input type="checkbox"/>	
Did your client have a difficult time adapting to places or people?	<input type="checkbox"/>	<input type="checkbox"/>	
Did your client engage in self-injurious behaviors?	<input type="checkbox"/>	<input type="checkbox"/>	
Was your client alert to their environment?	<input type="checkbox"/>	<input type="checkbox"/>	
Did your client interact with others?	<input type="checkbox"/>	<input type="checkbox"/>	

RISK ASSESSMENT	RECENT/ CURRENT	PAST	NONE / NA	COMMENTS
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prescription Pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nicotine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pornography/Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Technology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Non Suicidal Self Injury (NSSI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Suicidal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Homicidal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sexual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

RESILIENCE ASSESSMENT	COMMENTS
Who are trusted adults or social supports in the client's life?	
What are the norms that are important to the client/ values?	
What are the client's abilities and strengths?	
What are the client's hobbies or leisure activities?	
What are the client's aspirations or goals in life?	
What does the client do to take care of themselves?	

II. Client Psychosocial, Behavioral, Environmental & Social Functioning

Employment

Current Employment:	
Employment History:	

Education

Current/Highest Grade:	
Current School:	
School History:	
IEP/ 504 Plan:	
Attendance:	
Academic Functioning:	
Extracurricular Activities:	

Cultural

Cultural Considerations:	
Religious/Spiritual Beliefs:	

III. FAMILY INFORMATION

Name	Relationship and Status (excellent, good, fair, poor, estranged)

Other significant relationships: Relationship and Status (excellent, good, fair, poor, estranged)

Who all lives in client's home? Father Mother Siblings [specify ages: _____]
 Other: _____

Family History of Mental Health:

Father	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> None	Describe Treatment:
Mother	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> None	Describe Treatment:
Sibling(s)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> None	Describe Treatment:
Other	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> None	Describe Treatment:

Family History of Substance Abuse:

Father	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> None	Describe Treatment:
Mother	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> None	Describe Treatment:
Sibling(s)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> None	Describe Treatment:
Other	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> None	Describe Treatment:

SOCIAL HISTORY PART II: LIFE EVENTS CHECKLIST



Client Name: _____ MI: _____ Last Name: _____ DOB: _____

Please indicate current, past, or none for the following items listed:

LIFE EVENTS	RECENT	PAST	NONE / NA	COMMENTS
Death of a family member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neighborhood violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Victim of crime/violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bystander of crime/violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Victim of bullying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Victim of a fire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Caregiver separation/divorce	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Incarceration of Parent or Sibling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Illness of Family Member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abuse of drugs/alcohol by family member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Victim of natural disaster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Utilities shut off	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent moving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Homelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Significant illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Significant accident/injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Require Special Medical Attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Death or illness of classmate/school support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Involuntary school transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Coming out LGBTQ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Refugee/Immigrant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health of a family member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Deportation of a family member or loved one	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of pets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent change in caregiver/daycare provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Adoption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Separation from primary caregiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional/Mental Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neglect/Denial of Critical Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exposure to explicit material	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exposure to substances or violence utero	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Complications during pregnancy or birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	