Apex Downriver Behavioral Health

Child/Adolescent Health Screening

Child's name: _____ Date of birth: _____

Person completing form and relationship to child _____

Any allergies to medications?

Name of medication _____ Reaction _____

How would you describe your child's health overall? _____

Are immunizations current? Yes ___ No ____

Pregnancy, delivery, and infancy information

Did biological mother use any drugs or alcohol during pregnancy?

___ Alcohol ___Drugs (please list)_____ Tobacco____

Medications (please list) _____

Did the mother have any health problems during pregnancy?

Any complications during pregnancy or delivery?

Any health problems/birth defects at birth? _____

Early Childhood

Were developmental milestones met on time?

Any health concerns during childhood? _____

Current Medications

_____ dose/frequency_____ when started_____

_____ dose/frequency_____ when started_____

_____ dose/frequency_____ when started_____

_____ dose/frequency_____ when started_____

_____ dose/frequency_____ when started_____

Any supplements or nonprescription medications? _____

Check any of the following that the child has had in the past or currently has:

	Yes	No	Please Describe		Yes	No	Please Describe
Major accident or injury				Loss of Consciousness			
Hospitalization				Concussion			
Surgery				Headaches			
Adverse medication reaction				Hearing problems			
Allergies				Heart Disease			
Anemia				High blood pressure			
Arthritis				Thyroid problems			
Asthma				Hepatitis			
Birth defects				Kidney problems			
Bladder Problems				Liver problems			
Cancer				Lung problems			
Cerebral Palsy				Stroke			
Dental Problems				Vision problems			
Diabetes				Speech/language problems			
Epilepsy				Head Trauma			

Any other health problems or concerns (past or current)?

_____

_____

Has your child ever been hospitalized for medical reasons? _____

Any surgery? _____

Age of hospitalization Reason for hospitalization

_____ _____

_____ _____

Is the child sexually active? Yes ___ No ____

Is she pregnant? Yes ___ No ____

Does the child smoke? Yes ___ No ____

If yes, how often_____

If yes, how much_____

Client/Parent signature _____ Date _____

Based on the assessment (check one):

[ ] No further action required

[ ] Refer to primary care physician/pediatrician

[ ] Refer to urgent care/emergency room

Physical health was reviewed with client/parents Yes ___ No ____

Practitioner signature _____ Date _____

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FOODS MY CHILD EATS: Please place an X in the appropriate column

FOOD	Daily	3-5 times per week	1-3 times per week	Never or almost never	Used to eat, but not anymore
Artificial sweeteners					
Candy, desserts, sugar					
Carbonated beverages					
Caffeinated beverages					
Essential fatty acid rich foods (avocados, flax seeds)					
Fruit juice					
Fast foods					
Soy (tofu, veggie burger)					
Low fat foods					
Margarine					
Milk products					
Chocolate milk					
Whole milk					
2%, 1% or skim					
Cheese					
Bread, pasta, baked goods					
Vegetarian diet					
Vegan diet					
Meat					
Luncheon meats/hot dogs					
Fruit leather/granola bars					
Roasted nuts or seeds					
Fried foods					
Water, tap					
Water, filtered					

1. Was your child breast fed? **Y** **N** If yes, how long? _____ Any problems? _____

2. If bottle-fed, what brand of formula? _____ Begun at what age? _____

3. At what age were solid foods introduced? _____

4. What were your child's first foods? _____

5. What foods does your child crave? _____

6. What foods does your child avoid? _____

7. Does your child have constant need and desire for candy and sugar? _____

8. How does your child tolerate the introduction of new foods? _____

9. Any adverse reactions like fatigue or hyperactivity after eating certain foods? _____

10. Is your child a picky eater about textures/temperatures? _____

11. Any known allergies to food? _____

12. What percentage of your food is home-cooked? _____

13. How often do you eat out? _____

14. How often does your family eat dinner together? _____

15. Describe the typical atmosphere during meals: _____

16. Any other dietary concerns: _____

Client/Parent signature _____ **Date** _____

Based on the assessment (check one):

[ ] No further action required

[ ] Refer to primary care physician/pediatrician

[ ] Refer to urgent care/emergency room

[ ] Other: _____

Reviewed nutritional assessment with client/parents Yes ___ No ____

Practitioner signature _____ **Date** _____

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The Child PTSD Symptom Scale (CPSS) – Part I

Below is a list of problems that kids sometimes have after experiencing an upsetting event. Read each one carefully and circle the number (0-3) that best describes how often that problem has bothered you IN THE LAST TWO WEEKS

Please write down your most distressing event: _____

_____

Length of time since the event: _____

0	**1**	**2**	**3**
Not at all or only at one time	Once a week or less / once in a while	2 to 4 times a week / half the time	5 or more times a week / almost always

1)	0	1	2	3	Having upsetting thoughts or images about the event that came into your head when you didn't want them to
2)	0	1	2	3	Having bad dreams or nightmares
3)	0	1	2	3	Acting or feeling as if the event was happening again (hearing something or seeing a picture about it and feeling as if I am there again)
4)	0	1	2	3	Feeling upset when you think about it or hear about the event (for example, feeling scared, angry, sad, guilty, etc)
5)	0	1	2	3	Having feelings in your body when you think about or hear about the event (for example, breaking out into a sweat, heart beating fast)
6)	0	1	2	3	Trying not to think about it, talk about, or have feelings about the event
7)	0	1	2	3	Trying to avoid activities, people, or places that remind you of the traumatic event
8)	0	1	2	3	Not being able to remember an important part of the upsetting event
9)	0	1	2	3	Having much less interest in doing things you used to do.

0	1	2	3
Not at all or only at one time	Once a week or less / once in a while	2 to 4 times a week / half the time	5 or more times a week / almost always

10)	0	1	2	3	Not feeling close to people around you
11)	0	1	2	3	Not being able to have strong feelings (for example, being unable to cry or feel happy)
12)	0	1	2	3	Feeling as if your future plans or hopes will not come true (for example, you will not have a job or getting married or having kids)
13)	0	1	2	3	Having trouble falling or staying asleep
14)	0	1	2	3	Feeling irritable or having fits of anger
15)	0	1	2	3	Having trouble concentrating (for example, losing track of a story on television, forgetting what you read, not paying attention in class)
16)	0	1	2	3	Being overly careful (for example, checking to see who is around you and what is around you)
17)	0	1	2	3	Being jumpy or easily startled (for example, when someone walks up behind you)

The Child PTSD Symptom Scale (CPSS) - Part 2

Indicate below if the problems you rated in Part 1 have gotten in the way with any of the following areas of your life DURING THE PAST TWO WEEKS:

	Yes	**No**	
18)	Y	N	Doing your prayers
19)	Y	N	Chores and duties at home
20)	Y	N	Relationships with friends
21)	Y	N	Fun and hobby activities
22)	Y	N	Schoolwork
23)	Y	N	Relationships with your family
24)	Y	N	General happiness with your life