INNOVATIVE
HEALTH CARE CONCEPTS
115 E. 16th Street | Idaho Falls, ID 83404 | t. 208.523.6727 | f. 208.523.6729
Innovative Counseling Center

Welcome to Innovative HealthCare Concepts! Please fill out the following sections for your provider:

Name: _____ Date of Birth: _____

Specific Questions Regarding Psychiatric Problems:

Depression— Has your child had had a period of time in which they felt unhappy, depressed, irritable, or felt no interest in life consistently for at least two weeks or longer?

☐ Yes, now ☐ Yes, in the past ☐ No

Chronic Feelings of Unhappiness— Has your child had felt mildly unhappy or unable to enjoy life for many years, for no apparent reason?

☐ Yes, now ☐ Yes, in the past ☐ No

Suicide Attempts— Has your child had ever attempted suicide?

☐ Yes, now ☐ Yes, in the past ☐ No

Self-Harm—Besides attempting suicide, has your child had ever attempted to do physical harm himself/herself in other ways, such as cutting or burning themselves?

☐ Yes, now ☐ Yes, in the past ☐ No

High Periods or Mania— Has your child had moods that lasted at least one week or longer in which they have so much energy you did not sleep for several nights, or felt like they could accomplish many difficult tasks easily? Were they feeling so good that other people commented on their elevated mood?

☐ Yes, now ☐ Yes, in the past ☐ No

Psychotic Symptoms—Has your child had hallucinations, "heard voices", felt they had special powers or were receiving special messages, felt inappropriately suspicious people were trying to harm them?

☐ Yes, now ☐ Yes, in the past ☐ No

Chronic Tension or Anxiety—Has your child ever had problems with chronic anxiety, tension, nervousness, or constantly over worrying about minor concerns regardless of the situation (not related to anxiety attacks)?

☐ Yes, now ☐ Yes, in the past ☐ No

Panic Attacks—Has your child had anxiety attacks in which they felt like they were going to die, lose control, or were extremely frightened, anxious or uncomfortable?

☐ Yes, now ☐ Yes, in the past ☐ No

Panic Associated Fears—Has your child ever been afraid of going out of the house alone, going to the store/school, driving or using public transportation because of fear of having a panic attack?

☐ Yes, now ☐ Yes, in the past ☐ No

Obsessive Symptoms—Has your child had obsessions (ideas that seem senseless but keep repeating in their mind) or compulsions to repeat tasks such as repeatedly checking things, washing, or counting?

☐ Yes, now ☐ Yes, in the past ☐ No

Social Fears or Phobias—Has your child been fearful in specific social situations, felt uncomfortable doing things in front of other people or do they worry excessively about being embarrassed or humiliated in social situations?

☐ Yes, now ☐ Yes, in the past ☐ No

Post-Traumatic Symptoms—Has your child experienced a very traumatic event that has continued to bother them or cause emotional problems later in their life such as repeated nightmares or “flashbacks” of the event(s)?

☐ Yes, now ☐ Yes, in the past ☐ No

Phobias—Has your child had significant phobias such as heights, flying, closed spaces, insects, etc. that interfere with their life?

☐ Yes, now ☐ Yes, in the past ☐ No

Anorexia—Has your child ever been anorexic or purposely lost weight to obtain a weight below normal?

☐ Yes, now ☐ Yes, in the past ☐ No

Binge Eating or Bulimia-Has your child had eating binges associated with inducing vomiting, using laxatives, or exercising to the extreme?

☐ Yes, now ☐ Yes, in the past ☐ No

Chronic Physical Symptoms—Has your child had repeated periods of time in which they felt physically sick or worried about their health when no physical cause could be found?

☐ Yes, now ☐ Yes, in the past ☐ No

Chronic Pain—Has your child had problems with chronic pain such as headaches?

☐ Yes, now ☐ Yes, in the past ☐ No

If yes, please specify: _____

Sleep Problems: Has your child had sleep problems such as insomnia, oversleeping, frequent nightmares, or sleep-walking

☐ Yes, now ☐ Yes, in the past ☐ No

Compulsive Behaviors—Has your child had problems with compulsive behaviors such as spending, gambling, work, sexual behaviors, pornography, or other problematic compulsions?

☐ Yes, now ☐ Yes, in the past ☐ No

If yes, please specify:_____

Hyperactivity/Inattention—Was your child considered hyperactive as a young child, had Attention Deficit Hyperactivity Disorder, or has been treated with Ritalin or other stimulate medications?

☐ Yes, now ☐ Yes, in the past ☐ No

Oppositional Behaviors—Does your child argue with adults, defy rules, deliberately annoy others, blame others for his/her misbehavior or act easily annoyed, more than peers their age?

☐ Yes, now ☐ Yes, in the past ☐ No

Conduct Disorder Problems—Has your child repeatedly exhibited threatening behaviors, cruelty to people or animals, fire setting or other destruction of property, shoplifting or other stealing, lying, running away, school truancy, gang activity, etc.

☐ Yes, now ☐ Yes, in the past ☐ No

Temper-Anger Problems—Has your child had problems with their temper/anger?

☐ Yes, now ☐ Yes, in the past ☐ No

Please state the principal reason you are requesting a consultation or treatment:

Please describe the current episode of your child's problem/illness from the time of the first symptom to the present, including dates and significant events:

Please list any recent stressful events in your child's life:

_____

_____

_____

_____

Has your child ever had any past Counseling?

☐ Yes, now ☐ Yes, in the past ☐ No

If yes, please specify where, name of therapist, length of treatment, and any comments:_____

_____

_____

_____

_____

Has your child had any past hospitalizations or residential treatment for the treatment of Psychiatric, Behavioral, or Substance Use Problems?

☐ Yes, now ☐ Yes, in the past ☐ No

If yes please specify name of location, reason for hospitalization or type of problem, length of treatment, and any comments:_____

_____

_____

_____

_____

Medical History:

Weight: _____

If your child's weight increased or decreased by more than 20lbs during the last 2 years, please state the amount and explain the circumstances:_____

Height: What is your child's height in feet and inches?_____

Prenatal Medical Problems: Did your child's mother experience significant medical problems during her pregnancy, labor, or delivery?

☐ Yes ☐ No

If yes, please explain:_____

_____

Acute or Chronic Physical Illnesses: Please include past and present conditions and age or date of onset of conditions: _____

_____

_____

Seizures or Head Traumas with Loss of Consciousness or Amnesia: Please list date of trauma or date of onset and type of seizures, if applicable:_____

_____

_____

Surgeries: Please include type and date:_____

_____

_____

_____

Menstrual History: Please include regularity, duration and if your child has excessive pain or discomfort with periods:_____

_____

_____

Do your child's moods, depression, irritability, and/or irrationality change significantly with their menstrual periods or due to oral contraceptives?

☐ Yes ☐ No

If yes, please explain:_____

_____

Current Medical Symptoms: Please list any current physical symptoms including headaches or dizziness: ear, nose, or throat problems: heart problems, lung or respiratory problems, stomach, liver, or bowel problems, urinary tract or kidney problems, reproductive system problems, muscle, bone, or joint problems, skin disease, blood, immune, or hormonal problems, pain problems, etc.

_____

_____

_____

_____

_____

Family History Of Psychiatric Problems:

Please include psychiatric problems in your biological relatives, such as depression, bipolar (manic-depression), anxiety disorders (panic disorder, OCD, PTSD), schizophrenia, hyperactivity or attention deficit disorder, alcohol or drug abuse, anger or criminal problems, suicide, etc.:

Mother: _____

Maternal Parents and Siblings: _____

Maternal Cousins: _____

Father: _____

Paternal Parents and Siblings: _____

Paternal Cousins: _____

Brothers and Sisters: _____

Social History:

Where was your child born?_____

Where did your child live while growing up? Did they move around a lot? _____

_____

How many siblings does your child have and where do they fit in the order? How do hey get along with them?_____

_____

Please describe the family constellation while growing up, i.e. divorces, remarriages, and step-parents? _____

_____

Please give a brief description of your child's relationship with their Father or Step-Father

_____

_____

Please give a brief description of your child's relationship with their Mother or Step-Mother

_____

_____

Please describe the type of structure and discipline in the home. _____

_____

What are your child's hobbies and interests?_____

_____

Education/Occupation/#hours worked per week:

Father:_____
Mother:_____
Step-Parent:_____

Did/does your child experience any traumatic events or abuse while growing up?

☐ Yes, now ☐ Yes, in the past ☐ No

If yes, please specify and explain:_____

_____

Has this child or any other child in the family been **placed out of the home** or had family involvement with DFS (Division of Family Services)

☐ Yes, now ☐ Yes, in the past ☐ No

If yes, please specify and explain:_____

_____

How did your child do during grade school academically, socially, and behaviorally? Did they require an IEP or resource classes? _____

_____

_____

How did your child do during their teenage years academically, socially, and behaviorally?_____

_____

_____

Has your child been **sexually active**

☐ Yes ☐ No

Has your child experienced any **difficulties related to age, gender, culture, race, or religion?**

☐ Yes, now ☐ Yes, in the past ☐ No

If yes, please specify and explain:_____

_____

Has your child had any legal charges, past or present?

☐ Yes ☐ No

If yes, please explain: _____

_____

Is your child involved in a religious organization?

☐ Yes, now ☐ Yes, in the past ☐ No

If yes, please specify and explain:_____

_____

What are your child's **strengths**?_____

_____

What are your child's **weaknesses**? _____

_____

What are your child's **goals** for after high school?_____

_____

What would you like your child to accomplish in treatment?_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____