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

YOUTH SELF ASSESSMENT FOR MEDICATION MANAGEMENT

The purpose of this questionnaire is to obtain a comprehensive picture of your child's mental health background. In treatment, records are necessary to provide a high quality of service. By completing these questions, as fully and accurately as possible, it will help to ensure the highest quality of care. All records are kept confidential - no one outside this clinic will be permitted to see these records without your written permission. If you do not desire to answer a particular question, please just state "Do Not Care to Answer". If a question is not applicable please state N/A. Please type or print and use a pen.

Patient's Full Name:			Today's Date:
Mailing Address:			
City:		State:	Zip:
Mother's Full Name:			
Mother's Home Phone:	Mother's Cell Phone:	Mother's Work Phone:	
Father's Full name:			
Father's Home Phone:	Father's Cell Phone:	Father's Work Phone:	
Name and Relationship of the person(s) with whom the patient lives currently:			
Legal Guardian (if other than parent(s) with whom the patient lives):			
Name of person completing form and relationship to the patient:			
Who referred you to this clinic:			
Age:	DOB:	❑ Male	☐ Female

Race:	Religion:	School:
❑ Caucasian ❑ Hispanic ❑ African American ❑ Asian American ❑ Native American ❑ Other _____	❑ LDS (Mormon) ❑ Catholic ❑ Protestant _____ ❑ Jewish ❑ Muslim ❑ Other _____ ❑ None	_____ Current Grade: _____ Job (if any):

Please list the modality of treatment requested:	Internal Use Only
❑ Medications only ❑ Counseling / Psychotherapy only ❑ Both ❑ Uncertain	Date sent: Date returned:

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

(if necessary use another sheet of paper)

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

(if necessary use another sheet of paper)

Please list recent stressful life event:

(if necessary use another sheet of paper)

Clinician Comments

Specific Questions Regarding Psychiatric Problems

Depression - Has your child had a period of time in which he/she felt unhappy, depressed 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 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 attempted suicide?

☐ Yes, now ☐ Yes, in the past ☐ No

If yes, when and how: _____

Self Harm- Besides attempting suicide, Has your child ever attempted to do physical harm to him/herself in other ways, such as cutting and burning him/herself?

☐ Yes, now ☐ Yes, in the past ☐ No

If yes, how: _____

High Periods of Mania - Has your child had moods that lasted at least one week or longer in which he/she had so much energy he/she did not sleep for several nights, or felt he/she could accomplish many difficult tasks easily? Was he/she feeling so good that other people commented on his/her elevated mood?

☐ Yes, now ☐ Yes, in the past ☐ No

Psychotic Symptoms - Has your child had hallucinations, "heard voices", felt he/she had special powers or was receiving special messages, felt very suspicious people were trying to harm him/her, etc.?

☐ Yes, now ☐ Yes, in the past ☐ No

Chronic Tension or Anxiety - Has your child 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 brief anxiety in which he/she felt like he/she was going to die, lose control, or was 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 grocery store, 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 his/her mind) or compulsions to repeat tasks such as repeatedly checking things, washing, or counting?

☐ Yes, now ☐ Yes, in the past ☐ No

Social Fears and Phobias - Has your child been fearful in specific social situations, felt uncomfortable doing things in front of other people or does he/she 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 him/her or cause emotional problems later in his/her life such as repeated nightmares or "flashbacks" or 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 his/her life?

☐ Yes, now ☐ Yes, in the past ☐ No

If yes, please specify: _____

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 exorcising to extreme?

☐ Yes, now ☐ Yes, in the past ☐ No

Clinician Comments

Specific Questions Regarding Psychiatric Problems (cont'd)

Chronic Physical Symptoms - Has your child had repeated periods of time in which he/she felt physically sick or worried about his/her 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 been treated with Ritalin or another stimulant medication?
☐ 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 annoyed, more than peers his/her age? ☐
☐ Yes, now ☐ Yes, in the past ☐ No

Conduct Disorder Problems - Has your child repetitively exhibited threatening behavior, 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 his/her temper / anger?
☐ Yes, now ☐ Yes, in the past ☐ No

Substance Use / Abuse

Alcohol Use / Abuse- Does your child drink alcohol?
☐ Yes, now ☐ Yes, in the past ☐ No
☐ He/she drinks occasionally: _____ X per month.
☐ He/she drinks most days: _____ X per week.
☐ I believe he/she has a drinking problem.

Drug Abuse - Has your child abused "street" or illicit prescription drugs?
☐ Yes, now ☐ Yes, in the past ☐ No
If yes, what drugs(s) and what ages with each drug: _____

_____

Tobacco Products - Does your child smoke or use other tobacco products?
☐ Yes, now ☐ Yes, in the past ☐ No
If yes, how many packs per day and how many years: _____

_____

Caffeine - Does your child regularly drink coffee, tea or colas?
☐ Yes, now ☐ Yes, in the past ☐ No
If yes, how much per day: _____

If applicable, has your child experienced negative consequences of your substance use/ abuse (i.e. legal, health, relationship difficulties, job loss, etc.)?
☐ Yes, now ☐ Yes, in the past ☐ No ☐ Not Applicable

Clinician Comments

Past and Present Treatment with Counseling or Psychotherapy

Name of Therapist	Purpose of Treatment	Date Started	Length of Treatment	Was it Helpful?	Comments

Past Hospitalizations or Residential Treatment for the Treatment of Psychiatric, Behavioral or Substance Abuse Problems

Name of Institution/ Location	Reason for Hospitalization or Type of Problem	Date Started	Length of Treatment	Was it Helpful?	Comments

Past Treatment with Psychiatric Medications

(current medications listed later)

Below are listed a number of commonly used medications with significant psychiatric or emotional effects (please list in the boxes below):

Antidepressants		Mood Stabilizers	Tranquilizers	Sleeping Aids	Stimulants	Others
Prozac	Serzone	Lithium	Xanax	Ambien	Ritalin	Risperdal
Zoloft	Wellbutrin	Depakote	Klonopin	Sonata	Dexadrine	Zyprexa
Paxil	Amitriptyline	Tegretol	Ativan	Tranodone	Adderall	Seroquel
Luvox	Nortriptyline	Lamictal	Valium	Dalmane	Clondine	Geodon
Celexa	Desipramine	Neurontin	Buspar	Halcion	Concerta	Prolixin
Effexor	Anafranil	Topamax	Serax	Sominex	Provigil	Thorazine
Remeron	Cymbalta	Gabitril	Librium	Tylenol PM		Haldol
Lexapro	Nardil	Trileptal	Kava Kava	Benadryl		Antabuse
Sinequan	Parnate	Equetro		Lunesta		Abilify
Imipamine	SAM-E			Rozerem		Naltrexone
St. John's Wort						

Name of Medication	Max. Dose	Doctor	Reason for Use	Date Started	Length of Use	Response 0=none 1=poor 2=moderate 3=excellent	Side Effects

Medical History

Primary Care Physician: _____

Medical Specialists - Name and specialty: _____

_____

Weight - Current weight in pounds: _____lbs.

If your child's weight increased or decreased by more than 15 lbs. during the last year, please state the amount and explain the circumstances: _____

_____

Height - Your child's height in feet and inches: _____

Allergies - Please list all allergies, including medication allergies: _____

_____

_____

Prenatal Medical Problems - Did he/she or his/her mother experience significant medical problems during the pregnancy, labor, delivery or newborn period?

☐ Yes ☐ No

If yes, please explain: _____

_____

Was his/her mother using alcohol, cigarettes or illicit drugs during the pregnancy?

☐ Yes ☐ No

If yes, please explain: _____

_____

Developmental History - Please indicate, to the best of your memory, whether the ages of the following milestones were D (delayed), W/N (within normal range), or E (early):

Age first sat	☐ D	☐ W/N	☐ E	Skill with scissors	☐ D	☐ W/N	☐ E
Age first stood	☐ D	☐ W/N	☐ E	Skill at walk/run	☐ D	☐ W/N	☐ E
Age walked alone	☐ D	☐ W/N	☐ E	Skill handwriting	☐ D	☐ W/N	☐ E
Age used words	☐ D	☐ W/N	☐ E	Toilet training - Day	☐ D	☐ W/N	☐ E
Age used sentences	☐ D	☐ W/N	☐ E	Bowel & Bladder - Night	☐ D	☐ W/N	☐ E

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:

_____

_____

Acute or Chronic Physical Illness - Please include past and present conditions and age or date of onset of conditions:

_____

_____

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:

_____

_____

_____

_____

Clinician Comments

Current Medications

Please list all medications (prescribed or over the counter), herbs, or vitamins which your child has used on a regular basis during the last three months:

Medication	Dose	Date Started	Date Stopped	Prescribing Doctor	Reason for Use

Family History of Psychiatric Problems

Please include psychiatric problems, in your child's biological relatives, such as depression, bipolar (manic-depression), anxiety disorders (i.e. panic disorder, OCD, post traumatic stress…), schizophrenia, hyperactivity or attention deficit disorder, alcohol or drug abuse, anger or criminal problems, suicides, etc.:

Relative	Yes	No	?	Type of Problem(s)
Mother				
Mother's Parents & Sibs.				
Maternal Cousins				
Father				
Father's Parents & Sibs.				
Paternal Cousins				
Brothers & Sisters				

Clinician Comments

Social History

Place of Birth _____

Where did your child **live while growing up**; did he/she move frequently?

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 ☐No If yes, please explain:

What was your child like as a **infant**? I.e. hyperactive, moody, happy, anxious, temperamental, etc.

How did your child do during **grade school** academically, socially, and behaviorally? Did he/she require an IEP or resource class?

How many **siblings** does your child have and where does he/she fit in the order? How'd he/she get along with them?

How did/does your child do during his/her **teenage years** academically, socially, and behaviorally?

Please describe **family constellation** while growing up i.e. divorces, remarriages and step-parents, etc.

Have your child had any **legal problems**?
☐Yes ☐No If yes, please explain:

Please give a brief description of your child's **relationship** to his/her **father or step father**.

Have your child been **sexually active**?
☐Yes ☐No

Please give a brief description of your child's **relationship** to his/her **mother or step mother**.

Have your child experienced any **difficulties related to age, gender, culture, race or religion**?
☐Yes ☐No If yes, please describe:

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

Is your child involved in a **religious organization**?
☐Yes ☐No If yes, please describe:

Education/**Occupation**/#hours worked per week:
Father: _____
Mother: _____
Step Parent: _____

Please list your child's **strengths**?

What are your child's **hobbies and interests**?

Please list your child's **weaknesses**?

Did/does your child experience any **traumatic events or abuse** (physical, sexual, verbal, neglect) while growing up?
☐Yes ☐No If yes, please explain:

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

What would you **like your child to accomplish by coming to treatment**?

Clinician Comments

Innovative Health Care Concepts, Inc.
CONSENT FOR RELEASE AND EXCHANGE OF MEDICAL RECORDS AND PROTECTED HEALTH INFORMATION TO A THIRD PARTY

I, _____, (Name of Participant/Representative making Request), hereby authorize Innovative Health Care Concepts, Inc., (hereafter collectively referred to as IHCC) to release, exchange, and/or disclose the identified Personal Health Information to or from the following individual or entity:

Laboratory to release records to or request records from:

Name: _____

Address: _____

Phone: _____

Check the records you wish to release and disclose:

✓ Lab Work Ordered for Medication Management
☐ Other: _____ □ Other: _____
☐ Other: _____ □ Other: _____

I acknowledge that IHCC, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed above. I have reviewed IHCC's Notice of Privacy Practices (NOPP) and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify IHCC, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize IHCC to use and disclose verbally, by mail, fax or unencrypted email, the above checked information. I understand the information to be released may include records related to behavioral and/or mental health and/or alcohol and drug abuse treatment.

Date of this Request: _____

Purpose of this release: □ Insurance □ Legal □ Personal ✓ Treatment/Continued Care □ Other: _____

Release will cover the following service dates only: From: _____To: _____

** Send Lab Results to:

Dustin Potter
Fax: 208 523 6729
Phone: 208 523 6727

If information is disclosed from records protected by Federal confidentiality rules (42 CFR part 2), the Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted, in writing, by the person to whom it pertains or as otherwise permitted by 42 CFR part 2. This authorization will expire on the following date: _____. If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization.

_____ _____
Signature Date

State Relationship to Client: ☐ Self ☐ Parent ☐ Guardian ☐ Spouse ☐ Child ☐ Other: _____
