Catalpa Behavioral Health-History Form

Psychological Evaluation

Child's Name: _____ DOB: _____

Date: _____ Person Completing Form: _____

Child's primary language: _____ Parent's primary language: _____

Parent #1 name: _____ Age: _____ Education: _____

Child is: Biological Adopted (age: ____) Foster Guardian

Parent #2 name: _____ Age: _____ Education: _____

Child is: Biological Adopted (age: ____) Foster Guardian

Parent's marital status: Married Separated Divorced Never Married Deceased

Step parents: _____

Other household (family) members:

Name:	Age:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Custody: _____ Visitation Schedule: _____

Guardian ad litem: _____

Primary Care Provider: _____

Referral Source: _____

Other treating medical or mental health providers:

Name & Clinic:	Past	Present
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current mental health diagnoses: _____

Past mental health diagnoses: _____

Current medications (dosages): _____

Past medications: _____

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Reason for referral: _____

_____

What would you (as a parent) like to see happen as a result of your child's evaluation? _____

_____

Please circle your child's top 5 strengths:

Humor	Kind	Fair	Curious	Social
Creativity	Active	A Leader	Hopeful	Other: _____
Loving	Forgiving	Brave	Love of Learning	_____

Current Concerns (Please circle all that apply):

Behavioral	School Refusal	Rage	Fighting
Can't sit still	Academic Difficulties	Irritability	Cruelty to Others
Argumentative	Aggression	Low Self Esteem	Negative Peer Group
Defiant	Lies	Hypersensitivity	
Temper Outbursts			**Cognitive**
Delinquency	**Emotional**	**Interpersonal**	Poor Concentration
Rule Violations	Nervousness	Conflicts w/ Adults	Distractibility
Impulsivity	Panic Episodes	Conflicts w/ Siblings	Disorganization
Eating Problems	Phobias	Conflicts w/ Peers	Memory Difficulties
Sleep Problems	Depression	Lack of Friends	Learning Problems
Compulsive Behavior	Grief	Poor Social Skills	Language Problems
Alcohol Usage	Mood Instability	Inappropriate Social	Obsessive Thoughts
Drug Usage	Anger	Behavior	Racing Thoughts

Legal Problems:

Current: _____

Past: _____

County social worker/parole officer's name: _____

Pregnancy and Birth History

Age of parents at time of child's delivery: Mother _____ Father: _____

# of prior pregnancies: _____ # of prior miscarriages: _____

Fertility procedures: _____

Health problems during pregnancy (Please circle all that apply):

Vaginal Bleeding	Gestational Diabetes	Trauma	Alcohol
Toxemia	Blood Incompatibility	Antibiotics	Smoking
Hypertension	Fever/rash (e.g., flu, measles)	Illicit drugs: _____	

Medications: _____

Other: _____

Delivery was: Vaginal Cesarean Reason: _____

Baby was: Full term Premature (_____ weeks of gestation) Apgar Scores (if known): _____

Birth weight: _____ lbs _____ oz ICU days: _____ Days in hospital: _____

Birth Complications (Please circle all that apply):

Cord around neck	Lacking oxygen	Other: _____
Meconium staining	Jaundice	_____
Aspiration	Prolonged labor	_____

Medical problems after discharge: _____

_____

Post partum depression: _____

Developmental History

Motor

Age: Sat alone _____ Crawled _____ Stood _____ Walked _____

Fine Motor Delays (e.g., cutting, coloring, letter formation): _____
Gross Motor Delays (e.g., running, skipping, biking, playing ball): _____

Handedness: Right _____ Left _____ Both _____ Family history of left handedness: _____

Occupational Therapy (ages): _____ Physical Therapy (ages): _____

Speech/Language

Age spoke first word _____ Put 2-3 words together _____

Speech delays/problems (e.g., articulation, stuttering): _____
Oral motor problems (e.g., late drooling, poor sucking): _____

Speech/Language Therapy (ages): _____
Slow to learn alphabet? _____ Name colors? _____ Count? _____

Toileting

Age toilet trained: Urine _____ Bowel _____
Problems with: Daytime wetting _____ Nighttime wetting _____ Soiling _____
Current toileting problems: _____

Educational History

Current School: _____

Grade: _____ Placement: Regular Sp. Ed.: LD EBD ID/CD S/L OHI Autism TBI

Any grades skipped/repeated? _____

Teacher reports problems in (Please circle all that apply):

Reading	Written Language	Attention	Social Adjustment
Spelling	Organization	Behavior	Work Completion
Math	Penmanship		

Past history of academic/behavior difficulties reported by teachers in (Please circle all that apply):

Preschool Elementary School Middle School High School

Concerns: _____

Medical History

Has vision been checked? _____ Any problems? _____

Has hearing been checked? _____ Any problems? _____

CT/MRI? Date(s): _____ Results? _____

EEG? Dates(s): _____ Results? _____

List serious illnesses/injuries/surgeries/hospitalizations/inpatient treatment programs:

Date	Incident/Location
_____	_____
_____	_____
_____	_____

Does your child have a history of (Please circle all that apply):

Physical/sexual abuse	Loss of consciousness	Neglect	Clumsiness
Failure to thrive	Concussion(s)	Self injurious behaviors	Dizziness
Febrile seizures	Frequent ear infections	Staring spells	Drug allergies
Epilepsy	Ear tubes	Meningitis/encephalitis	Thyroid problems
Lead poisoning	Tics/twitching	Diabetes	Kidney problems
Asthma/allergies	Repetitive/stereotypic movements	Abdominal pain/vomiting	Hypertension
Headaches		Sleep difficulties	
Migraines	Cancer	Eating problems	

Describe head injuries (e.g., date, reason, loss of consciousness, changes in cognition/behavior):

_____

Social Behavior

Does your child get along with (Please circle all that apply):

Other children	Keep friends	Have a good sense of humor
Adults	Understand gestures	Participate in group activities
Have friends	Understand social cues	Have problems w/ peer pressure

Alcohol & Other Drug Abuse (AODA) History:

Does your child/adolescent use the following substances (please circle all that apply):

Caffeine	Alcohol	Other drugs
Nicotine	Marijuana	

How much and how often does your child use the above substances? _____

_____

Has your child/adolescent ever been treated for AODA problems? _____

Family History

	Biological Father	Biological Mother	Siblings	Paternal Grand-parents	Maternal Grand-parents	Other Relatives
Suicide attempt(s)	_____	_____	_____	_____	_____	_____
Completed suicide	_____	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____	_____
Bipolar disorder	_____	_____	_____	_____	_____	_____
Anxiety disorder	_____	_____	_____	_____	_____	_____
Panic disorder	_____	_____	_____	_____	_____	_____
OCD	_____	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____	_____
Autism/Aspergers	_____	_____	_____	_____	_____	_____
Learning problems	_____	_____	_____	_____	_____	_____
Alcoholism	_____	_____	_____	_____	_____	_____
Other drug abuse	_____	_____	_____	_____	_____	_____
Seizures/Epilepsy	_____	_____	_____	_____	_____	_____
Thyroid problems	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Other neurological	_____	_____	_____	_____	_____	_____

Child/Adolescent Psychiatry Screen (CAPS)

Child's Name:_____ Date of Birth :_____ Male _____ Female _____
Form Completed By:_____ Relationship to Child:_____

For each item below, check the one category that best describes your child ***during the past 6 months*.**
None = the child never or very rarely exhibits this behavior. **Mild** = the child exhibits this behavior approximately once per week, and few others notice or complain about this behavior. **Moderate** = the child exhibits this behavior at least three times per week, and others notice or comment on this behavior. **Severe** = the child exhibits this behavior almost daily, and multiple others complain about this behavior.
Past = the child used to have significant problems with this behavior, ***but not during the past 6 months*.**

	None	**Mild**	**Moderate**	**Severe**	***Past***
1. Has difficulty separating from parents* (* = or major caregiver/guardian)	_____	_____	_____	_____	_____
2. Worries excessively about losing or harm occurring to parents*	_____	_____	_____	_____	_____
3. Worries about being separated from parent* (getting lost or kidnapped)	_____	_____	_____	_____	_____
4. Resists going to school or elsewhere because of fears of separation	_____	_____	_____	_____	_____
5. Resists being alone or without parents*	_____	_____	_____	_____	_____
6. Has difficulty going to sleep without parent nearby	_____	_____	_____	_____	_____
7. Physical complaints (headache, stomach ache, nausea) when anticipating separation	_____	_____	_____	_____	_____
8. Has discrete periods of intense fear that peak within 10 minutes	_____	_____	_____	_____	_____
9. Has excessive, unreasonable fear of a specific object or situation	_____	_____	_____	_____	_____
10. Has recurrent thoughts that cause marked distress (e.g., fears germs)	_____	_____	_____	_____	_____
11. Driven to perform repetitive behaviors (e.g., handwashing, doing things 3 times)	_____	_____	_____	_____	_____
12. Has recurrent, distressing recollections of past difficult or painful events	_____	_____	_____	_____	_____
13. Worries excessively about multiple things (e.g., school, family, health, etc.)	_____	_____	_____	_____	_____
14. Goes to the bathroom at inappropriate times or places	_____	_____	_____	_____	_____
15. Makes noises, and is often unaware of them	_____	_____	_____	_____	_____
16. Makes repetitive, sudden, nonrhythmic movements	_____	_____	_____	_____	_____
17. Fails to pay close attention to details or makes careless mistakes	_____	_____	_____	_____	_____
18. Has difficulty sustaining attention during play or school activities	_____	_____	_____	_____	_____
19. Does not seem to listen when spoken to directly	_____	_____	_____	_____	_____
20. Does not follow through on instructions; fails to finish schoolwork/chores	_____	_____	_____	_____	_____
21. Has difficulty organizing tasks and activities	_____	_____	_____	_____	_____
22. Loses things necessary for tasks are activities (toys, pencils, etc.)	_____	_____	_____	_____	_____
23. Is easily distracted easily by irrelevant stimuli	_____	_____	_____	_____	_____
24. Is forgetful in daily activities	_____	_____	_____	_____	_____
25. Is fidgety or squirms in seat	_____	_____	_____	_____	_____
26. Has difficulty remaining seated	_____	_____	_____	_____	_____
27. Runs or climbs excessively; is restless	_____	_____	_____	_____	_____
28. Talks excessively	_____	_____	_____	_____	_____
29. Blurts out answers before questions have been completed	_____	_____	_____	_____	_____
30. Has difficulty waiting turn	_____	_____	_____	_____	_____
31. Interrupts or intrude on others	_____	_____	_____	_____	_____
32. Episodes of unusually elevated or irritable mood	_____	_____	_____	_____	_____
33. During this episode, grandiosity or markedly inflated self-esteem (Superhero)	_____	_____	_____	_____	_____
34. During this episode, is more talkative than usual/seems pressured to keep talking	_____	_____	_____	_____	_____
35. During this episode, races from thought to thought	_____	_____	_____	_____	_____
36. During this episode, is very distractible	_____	_____	_____	_____	_____
37. During this episode, excessively involved in things (too religious, hypersexual)	_____	_____	_____	_____	_____
38. During this episode, dangerous involvement in pleasurable activity (spending, sex)	_____	_____	_____	_____	_____
39. Depressed or irritable mood most of the day, most days for at least 1 week	_____	_____	_____	_____	_____
40. Loss of interest in previously enjoyable activities	_____	_____	_____	_____	_____
41. Notable change in appetite (not when dieting or trying to gain weight)	_____	_____	_____	_____	_____
42. Difficulty falling or staying asleep, or sleeping excessively through the day	_____	_____	_____	_____	_____

Child/Adolescent Psychiatry Screen (CAPS) - continued

	None	Mild	Moderate	Severe	*Past*
43. Others notice child is sluggish or agitated most of the time	_____	_____	_____	_____	_____
44. Loss of energy nearly every day	_____	_____	_____	_____	_____
45. Feelings of worthlessness or inappropriate guilt nearly every day	_____	_____	_____	_____	_____
46. Thinks about dying or wouldn't care if died	_____	_____	_____	_____	_____
47. Smokes cigarettes, drinks alcohol, OR abuses drugs (Circle all that apply)	_____	_____	_____	_____	_____
48. Has bad things happen when under the influence of substances	_____	_____	_____	_____	_____
49. Has made unsuccessful efforts to stop using a substance	_____	_____	_____	_____	_____
50. Is excessively worried about gaining weight, even though underweight	_____	_____	_____	_____	_____
51. If female, has stopped having menstrual cycles (after regularly having)	_____	_____	_____	_____	_____
52. Thinks he/she is fat, even though not overweight (pulls skin and claims is fat, etc.)	_____	_____	_____	_____	_____
53. Engages in binging and purging (eats excessively, then vomits or uses laxatives)	_____	_____	_____	_____	_____
54. Bullies, threatens, or intimidates others	_____	_____	_____	_____	_____
55. Initiates physical fights	_____	_____	_____	_____	_____
56. Uses weapons that could harm others	_____	_____	_____	_____	_____
57. Has been physically cruel to animals	_____	_____	_____	_____	_____
58. Has shoplifted or stolen items	_____	_____	_____	_____	_____
59. Has deliberately set fires	_____	_____	_____	_____	_____
60. Has deliberately destroyed others' property	_____	_____	_____	_____	_____
61. Lies to obtain goods or to avoid obligations	_____	_____	_____	_____	_____
62. Stays out at night despite parental prohibitions	_____	_____	_____	_____	_____
63. Has run away from home overnight on at least two occasions	_____	_____	_____	_____	_____
64. Is truant from school	_____	_____	_____	_____	_____
65. Loses temper	_____	_____	_____	_____	_____
66. Actively defies or refuses to comply with adult rules	_____	_____	_____	_____	_____
67. Deliberately annoys others	_____	_____	_____	_____	_____
68. Blames others for his/her mistakes or misbehavior	_____	_____	_____	_____	_____
69. Easily annoyed by others	_____	_____	_____	_____	_____
70. Is spiteful or vindictive	_____	_____	_____	_____	_____
71. Has unusual thoughts that others cannot understand or believe	_____	_____	_____	_____	_____
72. Hears voices speaking to him/her that others don't hear	_____	_____	_____	_____	_____
73. Does poorly at sports or games requiring physical coordination skills	_____	_____	_____	_____	_____
74. Has difficulty at school with: reading, writing, math, spelling (Circle all that apply)	_____	_____	_____	_____	_____
75. Had delayed speech or has limited language now	_____	_____	_____	_____	_____
76. Avoids eye contact during conversations	_____	_____	_____	_____	_____
77. Does not follow when others point to objects	_____	_____	_____	_____	_____
78. Shows little interest in others; emotionally out of sync with others	_____	_____	_____	_____	_____
79. Difficulty starting, stopping conversation; continues talking after others lose interest	_____	_____	_____	_____	_____
80. Uses unusual phrases, possibly over and over (speaks Disney or movie lines)	_____	_____	_____	_____	_____
81. Does not engage in make-believe play; plays more alone than with others	_____	_____	_____	_____	_____
82. Unusual preoccupations with objects or unusual routines (lines up 100's of cars, etc.)	_____	_____	_____	_____	_____
83. Difficulty with transitions; may be inflexible about adhering to routines or rules	_____	_____	_____	_____	_____
84. Shows unusual physical mannerisms (hand-flapping, shrieks, objects in mouth, etc.)	_____	_____	_____	_____	_____
85. Unusual preoccupations (schedules, own alphabet, weather reports, etc.)	_____	_____	_____	_____	_____

Thank you for answering each of these items. Please list any other symptoms that concern you:

_____

_____

_____