Reset Form

JUVENILE DEVELOPMENTAL HISTORY QUESTIONNAIRE

State Form 54393 (9-10)
INDIANA DEPARTMENT OF CORRECTION

*INSTRUCTIONS: To be completed by parent(s) or primary caregiver and returned to the Mental Health Department at the Youth's current correctional facility. Please carefully review all questions and answer to the best of your ability. Notably, not all questions will apply to your child / dependent. A mental health professional assigned to your child / dependent may contact you to clarify answers or obtain further information. Please describe **emotional / behavioral concerns** about youth, as they apply.*

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD / ADHD)

Please describe the age of **onset** for behaviors that you think may be associated with ADD / ADHD. Age of youth in years: _____

Please describe the **severity** of such behaviors.

☐ Mild ☐ Mild-moderate ☐ Moderate ☐ Moderate-severe ☐ Severe ☐ Incapacitating

Please describe the current **status** of such behaviors.

☐ Worse ☐ No Change ☐ Improved ☐ Resolved

Please describe the current **frequency** of such behaviors.

☐ Random ☐ Constant ☐ Daily ☐ Weekly ☐ Monthly

Please describe the youth's **quality of life**.

Behaviors create problems at home. ☐ Yes ☐ No
Behaviors create problems at school. ☐ Yes ☐ No
Behaviors create problems at work. ☐ Yes ☐ No
Behaviors create problems socially. ☐ Yes ☐ No

Other _____

Please describe the **context** of such behaviors.

Behaviors have persisted for greater than six (6) months. ☐ Yes ☐ No
Behaviors began before age seven (7). ☐ Yes ☐ No
Lead exposure ☐ Yes ☐ No

Other _____

Please describe **aggravating** factors.

Deadlines ☐ Yes ☐ No
Distractions ☐ Yes ☐ No
Stress ☐ Yes ☐ No
Tasks requiring attention to detail ☐ Yes ☐ No
☐ Nothing

Other _____

Please describe **relieving** factors.

Behavior therapy ☐ Yes ☐ No
Dietary modification ☐ Yes ☐ No
Stimulant medications ☐ Yes ☐ No
☐ Nothing

Other _____

Please describe **associated symptoms**.

Bored easily	☐ Yes ☐ No	Difficulty waiting turn	☐ Yes ☐ No	Disorganized	☐ Yes ☐ No
Distracted easily	☐ Yes ☐ No	Emotionally labile	☐ Yes ☐ No	Excitable	☐ Yes ☐ No
Fidgets / squirms	☐ Yes ☐ No	Frequent careless mistakes	☐ Yes ☐ No	Frustrated easily	☐ Yes ☐ No
Impulsive	☐ Yes ☐ No	Inattentive	☐ Yes ☐ No	Loses / forgets things	☐ Yes ☐ No
Poor self-image	☐ Yes ☐ No	Reckless	☐ Yes ☐ No	Restless	☐ Yes ☐ No
Short attention span	☐ Yes ☐ No	Talks excessively	☐ Yes ☐ No	Unable to follow directions	☐ Yes ☐ No

☐ No associated symptoms

Other _____

Additional comments:

DEPRESSION

Please describe the age of **onset** for behaviors that you think may be associated with depression. Age of youth in years: _____

List the year of the **first episode** of depressive behavior or symptoms. _____

If treated, list the **initial visit date** *(month, day, year)*. _____

Please describe the current **frequency** of such behaviors.

- ☐ Several days in the past two (2) weeks
- ☐ More than half the days in the past two (2) weeks
- ☐ Nearly every day in the past two (2) weeks
- ☐ Two (2) years or more without a significant break in symptoms

Other _____

Please describe the current **status** of such behaviors.

☐ New episode ☐ Improved ☐ Remission ☐ Unchanged ☐ Worsening

Please describe the **severity** of such behaviors.

☐ Mild ☐ Mild-moderate ☐ Moderate ☐ Moderate-severe ☐ Severe ☐ Incapacitating

Please describe **context / risk factors** associated with youth's past medical / psychological history.

- ☐ Alcohol use
- ☐ Childhood abuse or neglect
- ☐ Death of a friend or loved one
- ☐ Financial worries
- ☐ Medication: _____
- ☐ Recent childbirth
- ☐ Relationship problems
- ☐ Social isolation
- ☐ Substance abuse
- ☐ Unemployment
- ☐ Victim of abuse or violence

Other _____

Please describe the youth's l**evel of functioning** with difficulty in meeting home, work, or social obligations.

☐ Extremely ☐ Not at all ☐ Somewhat ☐ Very

Please describe **aggravating** factors.

- ☐ Alcohol use
- ☐ Conflict or stress at home or work
- ☐ Lack of sleep
- ☐ Medications
- ☐ Traumatic memories
- ☐ Winter season
- ☐ Nothing

Other _____

Please describe **relieving** factors.

- ☐ Alcohol
- ☐ Conversing
- ☐ Drugs
- ☐ Exercise
- ☐ Light
- ☐ Medication
- ☐ Nothing
- ☐ Rest
- ☐ Spring season

Other _____

Please describe **associated symptoms**.

Anxious, fearful thoughts	☐ Yes ☐ No	Compulsive thoughts or behaviors	☐ Yes ☐ No
Depressed mood	☐ Yes ☐ No	Diminished interest or pleasure	☐ Yes ☐ No
Fatigue or loss of energy	☐ Yes ☐ No	Feeling of guilt or worthlessness	☐ Yes ☐ No
Hallucinations	☐ Yes ☐ No	Manic episodes	☐ Yes ☐ No
Panic attacks	☐ Yes ☐ No	Poor concentration, indecisiveness	☐ Yes ☐ No
Restlessness or sluggishness	☐ Yes ☐ No	Significant change in appetite (weight loss or gain > 5%)	☐ Yes ☐ No
Sleep disturbance	☐ Yes ☐ No	Thoughts of death or suicide	☐ Yes ☐ No

☐ No associated symptoms

Other _____

Additional comments:

OTHER AREA OF CONCERN

Such as: ☐ Anxiety ☐ Trauma ☐ Psychosis ☐ Self-harm ☐ Violence toward others

Other _____

Please describe the age of **onset** for behaviors that you think may be associated with the other area of concern. Age of youth in years: _____

Please describe the **severity** of such behaviors.

☐ Mild ☐ Mild-moderate ☐ Moderate ☐ Moderate-severe ☐ Severe ☐ Incapacitating

Please describe the current **frequency** of such behaviors.

☐ Two (2) times per week	☐ Three (3) times per week	☐ All the time
☐ Almost all the time	☐ Almost always	☐ Almost never
☐ Always	☐ Constantly	☐ Daily
☐ Every month	☐ Every two (2) months	☐ Frequently
☐ Intermittently	☐ Never before	☐ Morning only
☐ Night only	☐ Occasionally	☐ Persistently
☐ Rarely	☐ Weekly	☐ No pattern

Other _____

Please describe the current **status** of such behaviors.

☐ Improved	☐ Improvement, gradual	☐ Improvement, rapid
☐ Improvement, steady	☐ No change	☐ No relief
☐ Relief, temporary	☐ Resolution of problem	☐ Worse
☐ Worse, gradually	☐ Worse, rapidly	☐ Worse, steadily

Please describe the youth's **level of functioning** with difficulty in meeting home, work, school, or social obligations.

☐ Extremely ☐ Not at all ☐ Somewhat ☐ Very

Please describe **aggravating** factors that seem to make the behavior or symptom worse.

Please describe **relieving** factors that seem to make the behavior or symptom better.

Please describe **associated symptoms** or behaviors displayed by the youth.

Additional comments:

OTHER AREA OF CONCERN

Such as: ☐ Anxiety ☐ Trauma ☐ Psychosis ☐ Self-harm ☐ Violence toward others

Other _____

Please describe the age of **onset** for behaviors that you think may be associated with the other area of concern. Age of youth in years: _____

Please describe the **severity** of such behaviors.

☐ Mild ☐ Mild-moderate ☐ Moderate ☐ Moderate-severe ☐ Severe ☐ Incapacitating

Please describe the current **frequency** of such behaviors.

☐ Two (2) times per week ☐ Three (3) times per week ☐ All the time
☐ Almost all the time ☐ Almost always ☐ Almost never
☐ Always ☐ Constantly ☐ Daily
☐ Every month ☐ Every two (2) months ☐ Frequently
☐ Intermittently ☐ Never before ☐ Morning only
☐ Night only ☐ Occasionally ☐ Persistently
☐ Rarely ☐ Weekly ☐ No pattern

Other _____

Please describe the current **status** of such behaviors.

☐ Improved ☐ Improvement, gradual ☐ Improvement, rapid
☐ Improvement, steady ☐ No change ☐ No relief
☐ Relief, temporary ☐ Resolution of problem ☐ Worse
☐ Worse, gradually ☐ Worse, rapidly ☐ Worse, steadily

Please describe the youth's **level of functioning** with difficulty in meeting home, work, school, or social obligations.

☐ Extremely ☐ Not at all ☐ Somewhat ☐ Very

Please describe **aggravating** factors that seem to make the behavior or symptom worse.

Please describe **relieving** factors that seem to make the behavior or symptom better.

Please describe **associated symptoms** or behaviors displayed by the youth.

Additional comments:

OTHER AREA OF CONCERN *(continued)*

Please describe any **outpatient mental health treatment** that the youth was receiving in the community at the time of detention or incarceration.

- ☐ None
- ☐ Day treatment (setting with both schooling and mental health treatment)
- ☐ After care (follow up treatment after release from a psychiatric hospital)
- ☐ Psychiatric medications
- ☐ Psychotherapy (individual, group, or family counseling)

Other _____

Briefly describe the nature of such treatment:

SOCIAL HISTORY

Youth **primarily resides** with:

- ☐ Mother (biological)
- ☐ Father
- ☐ Two (2) mothers
- ☐ Two (2) fathers
- ☐ Adoptive mother
- ☐ Adoptive father
- ☐ Stepmother
- ☐ Stepfather
- ☐ Foster mother
- ☐ Foster father
- ☐ Aunt
- ☐ Uncle
- ☐ Grandmother
- ☐ Grandfather
- ☐ Sister(s)
- ☐ Brother(s)
- ☐ Half sister(s)
- ☐ Half brother(s)
- ☐ Multiple families
- ☐ Stepbrother(s)

Other _____

Youth **secondarily resides** with:

- ☐ Mother (biological)
- ☐ Father
- ☐ Two (2) mothers
- ☐ Two (2) fathers
- ☐ Adoptive mother
- ☐ Adoptive father
- ☐ Stepmother
- ☐ Stepfather
- ☐ Foster mother
- ☐ Foster father
- ☐ Aunt
- ☐ Uncle
- ☐ Grandmother
- ☐ Grandfather
- ☐ Sister(s)
- ☐ Brother(s)
- ☐ Half sister(s)
- ☐ Half brother(s)
- ☐ Multiple families
- ☐ Stepbrother(s)

Other _____

Please describe youth's **tobacco exposure**.

Smokes at home: ☐ Yes ☐ No Smokes outside only: ☐ Yes ☐ No

Please describe typical **child care** arrangements for youth.

- ☐ Mother Days per week _____
- ☐ Father Days per week _____
- ☐ Grandparent Days per week _____
- ☐ Sibling Days per week _____
- ☐ Nanny Days per week _____
- ☐ Daycare Days per week _____
- ☐ Sitter Days per week _____

Name of daycare facility _____

Please describe youth's **hand dominance**. ☐ Right ☐ Left

Please describe youth's **parent / caretaker's occupation**.

Occupation of father _____

Occupation of caretaker _____

Occupation of mother _____

SOCIAL HISTORY *(continued)*

Please describe youth's **parents' relationship**.

☐ Married ☐ Divorced ☐ Separated
☐ Never together ☐ Father incarcerated ☐ Mother incarcerated

Please describe youth's **relationships.**

Cooperates with family / friends ☐ Yes ☐ No Cooperates with teachers ☐ Yes ☐ No
Has enough friends ☐ Yes ☐ No Has friends of both sexes ☐ Yes ☐ No
Concerns about relationships with family / friends / others ☐ Yes ☐ No

Please briefly describe **concerns** about youth's relationship with others:

Please describe youth's **relationship with sibling(s)**.

☐ Good ☐ Strained ☐ Wonderful Other _____

Please describe youth's **home environment**.

Language(s) spoken at home: _____

Neighborhood type:

☐ Inner-city ☐ Rural ☐ Suburban ☐ Urban Other _____

Home type:

☐ Apartment ☐ Condominium ☐ Duplex ☐ Single-family Other _____

Home age:

☐ New ☐ Less than ten (10) years ☐ Ten (10) to Twenty-five (25) years ☐ Pre 1978
☐ Pre 1960 ☐ Pre 1950 ☐ Historic ☐ Unknown

Home affords adequate privacy. ☐ Yes ☐ No Home affords adequate safety. ☐ Yes ☐ No

Water is chlorinated ☐ Yes ☐ No Water is fluoridated ☐ Yes ☐ No
Lead in the home *(if known)* ☐ Yes ☐ No
Water Source is: ☐ Municipal ☐ Well

Please describe youth's **safety**

Uses bike / skating helmet ☐ Yes ☐ No Carbon Monoxide detector ☐ Yes ☐ No
Smoke detectors in home ☐ Yes ☐ No Radon in home ☐ Yes ☐ No ☐ Untested ☐ Treated
Pets / animals at home ☐ Yes ☐ No Type of animals: _____
Firearms in the home ☐ Yes ☐ No Number of firearms: _____
Locked firearm storage ☐ Yes ☐ No Trigger guard ☐ Yes ☐ No
Ammunition stored separately ☐ Yes ☐ No Unloaded for storage ☐ Yes ☐ No

Firearms kept for:

☐ Recreation ☐ Hunting ☐ Occupation ☐ Protection

Comments related to firearms:

Please describe youth's **education**.

Name of school _____

Grade in school _____

Grades earned:

☐ All A's ☐ A's and B's ☐ B's ☐ B's and C's ☐ C's ☐ C's and D's ☐ D's ☐ D's and F's ☐ All F's

SOCIAL HISTORY *(continued)*

Learning disability ☐ Yes ☐ No If yes, please describe:

☐ Articulation disorder ☐ Dyscalculia ☐ Dyslexia ☐ Expressive language disorder

☐ Motor skills disorder ☐ Receptive language disorder ☐ Writing disorder

Other _____

Special needs ☐ Yes ☐ No If yes, please describe:

☐ ADD ADHD ☐ Behavior problems ☐ Excessive absences ☐ Failing ☐ IEP in place

☐ IEP pending ☐ Math ☐ Math and reading ☐ Physical disability ☐ Reading

☐ Special needs classroom ☐ SPED / LD ☐ Speech

Gifted program ☐ Yes ☐ No

Performing: ☐ Below grade level ☐ At grade level ☐ Above grade level

Likes school ☐ Yes ☐ No Truancy ☐ Yes ☐ No

Youth's educational goals:

☐ Get a job ☐ College ☐ Graduate form high school ☐ Military career ☐ Professional school

Other _____

Repeated grades ☐ Yes ☐ No Grade(s) repeated _____

Why? _____

History of suspension or expulsion ☐ Yes ☐ No

Why? _____

Please describe youth's **sleep**.

Takes naps ☐ Yes ☐ No Sleeps with parents / caretakers ☐ Yes ☐ No

Sleeps through the night ☐ Yes ☐ No Minimum of 8.5 hours sleep nightly ☐ Yes ☐ No

Nightmares / sleep problems ☐ Yes ☐ No

Further **detail** about youth's sleep quality.

☐ No concerns ☐ Has difficulty falling asleep ☐ Has difficulty staying asleep ☐ Has night terrors

☐ Has nightmares ☐ Has restless sleep ☐ Sleepwalks ☐ Sleeps through the night

Further **detail** about youth's sleep location.

☐ In own room ☐ In parents' bed ☐ In parents' room ☐ In room with sibling

Other _____

Further **detail** about youth's sleep method.

☐ On own ☐ Only when read to ☐ Only with parent present Other _____

Further **detail** about youth's sleep position.

☐ On abdomen ☐ On back ☐ On side Other _____

Further **detail** about youth's sleep time.

Number of naps per day: _____ Number of hours sleep per day: _____

Please describe youth's **activity**.

Hours per day of exercise / sports: _____ Hours per day of TV / computer games: _____

Further **detail** about youth's type of exercise.

☐ Aerobic ☐ Ballet ☐ Baseball / softball ☐ Basketball ☐ Cheerleading ☐ Cycling

☐ Football ☐ Golf ☐ Gymnastics ☐ Hiking ☐ Hockey ☐ Dancing

☐ Jogging ☐ Martial arts ☐ Motor sports ☐ Soccer ☐ Swimming ☐ Walking

☐ Weights ☐ Wrestling Other _____

Further **detail** about youth's type of activities.

☐ After school program ☐ Chorus ☐ Drama ☐ Musical instrument ☐ School club

Other _____

SOCIAL HISTORY *(continued)*

Youth had a job prior to incarceration. ☐ Yes ☐ No If yes, how many hours worked per week? _____

Youth has a TV in the bedroom. ☐ Yes ☐ No If yes, how many hours of TV / computer games per day? _____

Please describe youth's recent travels.

☐ Out of state Where? _____

☐ Out of country Where? _____

☐ Travel exposure To what? _____

ADDITIONAL SOCIAL HISTORY

Please describe youth's history of **tobacco use**.

☐ Yes ☐ No ☐ Formerly If yes, what type of tobacco?

☐ Chewing Amount per day _____

☐ Cigarettes Amount per day _____

☐ Smokeless (dip) Amount per day _____

If formerly, year quit:

Chewing _____ Cigarettes _____ Smokeless _____

Please describe youth's history of **alcohol use.**

☐ Yes ☐ No ☐ Formerly If yes or formerly: Age started _____ Year quit _____

What type(s) of alcohol? _____

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Occasionally ☐ Socially

Amount per day: _____ Last drink: _____

Sought treatment for alcohol abuse. ☐ Yes ☐ No Date of last treatment *(month, day, year)* _____ Number of times: _____

Had withdrawal problems, seizures or blackouts from alcohol or drugs. ☐ Yes ☐ No

Involved in a 12-step program ☐ Yes ☐ No If yes, ☐ Currently or ☐ Formerly

Emergency medical attention required due to intoxication. ☐ Yes ☐ No If yes, number of times _____

Family history of alcoholism. ☐ Yes ☐ No

If yes, name of family member(s) _____

Please describe youth's history of **drug use / abuse:**

☐ Yes ☐ No ☐ Formerly If yes or formerly: Age started _____ Year quit _____

What type(s) of drugs? _____

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Occasionally ☐ Socially

Route taken: _____

Sought treatment for drug abuse ☐ Yes ☐ No Date of last treatment *(month, day, year)* _____ Number of times: _____

Had withdrawal problems, seizures or blackouts from alcohol or drugs? ☐ Yes ☐ No

Involved in a 12-step program? ☐ Yes ☐ No If yes, ☐ Currently or ☐ Formerly

Emergency medical attention required due to drug use? ☐ Yes ☐ No If yes, number of times _____

Family history of drug abuse? ☐ Yes ☐ No

If yes, name of family member(s) _____

Please describe youth's **psychiatric history.**

History of suicidal thoughts. ☐ Yes ☐ No History of homicidal thoughts. ☐ Yes ☐ No

ADDITIONAL SOCIAL HISTORY *(continued)*

Treated for psychiatric problem. ☐ Yes ☐ No If yes, please list diagnoses:

Diagnoses: _____ Age at time of diagnosis: _____

Diagnoses: _____ Age at time of diagnosis: _____

Name of Psychiatrist _____ Telephone number _____

Name of Therapist _____ Telephone number _____

Family history of psychiatric problems. ☐ Yes ☐ No

If yes, please describe:

Please describe youth's child abuse history.

Does youth have a confirmed history of child abuse? ☐ Yes ☐ No If yes, ☐ Ongoing or ☐ Past

Offender 1 _____ Type of abuse: ☐ Physical ☐ Sexual ☐ Verbal

Offender 2 _____ Type of abuse: ☐ Physical ☐ Sexual ☐ Verbal

Offender in home ☐ Yes ☐ No Restraining order in place ☐ Yes ☐ No Suspected child abuse ☐ Yes ☐ No

Suspected offender 1 _____ Type of abuse: ☐ Physical ☐ Sexual ☐ Verbal

Suspected offender 2 _____ Type of abuse: ☐ Physical ☐ Sexual ☐ Verbal

Has youth ever been placed in a girls' / boys' home or foster home? ☐ Yes ☐ No

Has youth been convicted of a sexual offense? ☐ Yes ☐ No

Please describe youth's child neglect history.

History of neglect. ☐ Yes ☐ No Offender _____

Reason _____

Suspected neglect. ☐ Yes ☐ No Offender _____

Reason _____

DCS involvement. ☐ Yes ☐ No Case Worker _____

Telephone number _____

Please describe youth's incarceration history.

History of incarceration. ☐ Yes ☐ No

Duration of incarceration from _____*(month, day, year)* to _____*(month, day, year)*

Crime convicted of _____

Duration of probation from _____*(month, day, year)* to _____*(month, day, year)*

Duration of incarceration (dates) from _____*(month, day, year)* to _____*(month, day, year)*

Crime convicted of _____

Duration of probation (dates) from _____*(month, day, year)* to _____*(month, day, year)*

Duration of incarceration (dates) from _____*(month, day, year)* to _____*(month, day, year)*

Crime convicted of _____

Duration of probation (dates) from _____*(month, day, year)* to _____*(month, day, year)*

Duration of incarceration (dates) from _____*(month, day, year)* to _____*(month, day, year)*

Crime convicted of _____

Duration of probation (dates) from _____*(month, day, year)* to _____*(month, day, year)*

ADDITIONAL SOCIAL HISTORY *(continued)*

Please describe youth's **sexual practices.**

Previously sexually active. ☐ Yes ☐ No Sometimes condom use ☐ Yes ☐ No

Orientation: ☐ Bisexual ☐ Heterosexual ☐ Homosexual

Birth control methods used: _____ Birth control methods discussed: _____

Number of current sexual partners: _____ Number of lifetime sexual partners: _____

Ever been pregnant? ☐ Yes ☐ No Ever had an abortion? ☐ Yes ☐ No

Parent / caretaker awareness: _____

Please describe youth's history of **STDs**.

HIV status:

☐ Positive Date tested *(month, day, year):* _____ ☐ Negative Date tested *(month, day, year):* _____

☐ Not tested AIDS: ☐ Positive ☐ Negative

History of STDs:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Risk factors for STDs.

☐ History of blood transfusions ☐ History of IV drug abuse ☐ High risk sexual partner

☐ Homosexual sex ☐ Multiple sexual partners ☐ No risk factors

☐ Prostitution ☐ Sex with hepatitis-infected person ☐ Sexually active before age eighteen (18)

☐ Unprotected sex Other _____

Name of parent / caretaker _____

Parent / caretaker comments:

Provider comments:

Please describe youth's **psychiatric history.**

Diagnosis / Problem: _____ Date of onset *(month, day, year):* _____

Type of treatment *(counseling, meds)*: _____ Date of treatment *(month, day, year):* _____

Treatment setting *(hospital, outpatient):* _____

Name of provider: _____

Treatment outcome: ☐ Failed ☐ Improved ☐ Resolved ☐ Successful ☐ Worsened

Other _____

Comments:

ADDITIONAL SOCIAL HISTORY *(continued)*

Diagnosis / Problem: _____ Date of onset *(month, day, year):* _____

Type of treatment (counseling, meds): _____ Date of treatment *(month, day, year):* _____

Treatment setting (hospital, outpatient): _____

Name of provider: _____

Treatment outcome: ☐ Failed ☐ Improved ☐ Resolved ☐ Successful ☐ Worsened

Other _____

Comments:

Diagnosis / Problem: _____ Date of onset *(month, day, year):* _____

Type of treatment (counseling, meds): _____ Date of treatment *(month, day, year):* _____

Treatment setting (hospital, outpatient): _____

Name of provider: _____

Treatment outcome: ☐ Failed ☐ Improved ☐ Resolved ☐ Successful ☐ Worsened

Other _____

Comments:

Diagnosis / Problem : _____ Date of onset *(month, day, year):* _____

Type of treatment (counseling, meds): _____ Date of treatment *(month, day, year):* _____

Treatment setting (hospital, outpatient): _____

Name of provider: _____

Treatment outcome: ☐ Failed ☐ Improved ☐ Resolved ☐ Successful ☐ Worsened

Other _____

Comments:

Name of psychiatrist _____ Telephone number _____

Name of therapist _____ Telephone number _____

* Correctional mental health professionals to obtain consent for release of information on above mentioned community providers from the facility Superintendent / Legal Guardian.

Please describe youth's **psychiatric medication history.**

* Correctional health professionals need below information to verify past prescriptions.

Medication type _____ Date last taken *(month, day, year)* _____

Name of Pharmacy _____ Telephone number _____

Name of prescribing clinic / doctor _____

Telephone number _____

Medication type _____ Date last taken *(month, day, year)* _____

Name of Pharmacy _____ Telephone number _____

Name of prescribing clinic / doctor _____

Telephone number _____

ADDITIONAL SOCIAL HISTORY *(continued)*

Medication type _____ Date last taken *(month, day, year)* _____

Name of Pharmacy _____ Telephone number _____

Name of prescribing clinic / doctor _____

Telephone number _____

Medication type _____ Date last taken *(month, day, year)* _____

Name of Pharmacy _____ Telephone number _____

Name of prescribing clinic / doctor _____

Telephone number _____

If applicable, please list youth's **allergies:**

Please describe youth's **nutritional status.**

Number of meals a day: _____

Decreased appetite ☐ Yes ☐ No Duration of decreased appetite: _____

Weight gain ☐ Yes ☐ No Time frame: _____ Amount: _____

Weight loss ☐ Yes ☐ No Time frame: _____ Amount: _____

DEVELOPMENTAL HISTORY

Please describe youth's **pregnancy / birth history.**

ANTENATAL

Maternal age during pregnancy _____ Estimate date of conception *(month, day, year)* _____ Marital status _____

Lived with father of baby ☐ Yes ☐ No _____

Prenatal care given ☐ Yes ☐ No If yes, ultrasound results: ☐ Normal ☐ Abnormal

Describe any abnormal results below:

☐ Birth marks ☐ Cardiac abnormalities ☐ Down syndrome markers ☐ GI abnormalities

☐ Musculoskeletal abnormalities ☐ Neuro abnormalities ☐ Renal abnormalities

Other _____

Maternal illness / complications ☐ Yes ☐ No If yes, please describe below:

☐ Gestational diabetes ☐ Pregnancy-induced hypertension ☐ Sickle cell disease

☐ Diabetes (NIDDM) ☐ Hypertension ☐ Sickle cell trait

☐ Diabetes (IDDM) ☐ Eclampsia ☐ Underlying cardiac disease

☐ Underlying renal disease ☐ Surgery during pregnancy Other _____

Maternal infections ☐ Yes ☐ No If yes, please describe below:

☐ Rubella ☐ Parvovirus ☐ Urinary tract ☐ B strep ☐ Syphilis ☐ Hepatitis B ☐ CMV ☐ HIV

Other _____

Please list any medications taken during pregnancy.

Alcohol use ☐ Yes ☐ No Frequency _____

Tobacco use ☐ Yes ☐ No Packs a day _____

Marijuana ☐ Yes ☐ No Frequency _____

Other types _____

DEVELOPMENTAL HISTORY (continued)

LABOR AND DELIVERY

Type of delivery _____

Gestational age (weeks) _____ (days) _____ premature Birth weight _____

Other _____

Please describe anything significant about youth's hospital stay after birth (e.g., fetal distress, stay in NICU, birth defects, medication given).

Please describe anything significant about youth's discharge from the hospital (e.g., feeding history, weight, referral to social services, adoption).

DEVELOPMENTAL MILESTONES

MILESTONE	EARLY	ON TIME	LATE	UNKNOWN
Smiled directly at parent or turned toward speaker.				
Slept mostly through the night				
Sat up				
Crawled				
Said single words clearly				
Spoke in sentences				
Walked unassisted				
Ate with a fork or spoon with help				
Toilet trained				
Dressed unassisted				
Rode a two-wheel bike without training wheels				
Reading				
Puberty				

FAMILY HISTORY

Please describe youth's **behavioral health family history.**

DIAGNOSIS	FAMILY MEMBER	NAME	AGE DIAGNOSED	COMMENT

Please describe youth's interactions with family members.

☐ Supportive ☐ Strained ☐ Dysfunctional ☐ No family ☐ Estranged (separated, not speaking, or on bad terms)

Other _____

FAMILY HISTORY *(continued)*

Please describe youth's **family resources / strengths.**

Please describe youth's **strengths / coping skills / resources / support network.**

How does the youth handle anger?

How does the youth handle stress?

Who comprised the youth's current support network?.

☐ None ☐ Case worker ☐ Children ☐ Clergy ☐ Father ☐ Friends ☐ Mother

☐ Neighbors ☐ Siblings ☐ Significant other Other _____

What are the youth's resources?

Please describe youth's **significant life events.**

History of trauma:

History of emotional abuse:

Risk issues:

☐ Homicidal thoughts ☐ Medical condition ☐ Suicidal thoughts ☐ High risk behavior

☐ Fire setting ☐ High impulsivity / aggression ☐ Psychosis ☐ Self-injury

☐ Serious suicide attempts ☐ Lack of support ☐ Non-compliance with treatment ☐ Family violence

☐ Substance abuse Other _____

History of separation / loss:

Please return questionnaire to the below address:

Fax number :

Name of student	IDOC number
Name of parent / caretaker completing form	Date (month, day, year)