Advance Potential
PSYCHOLOGICAL SERVICES

Child and Youth Background Information

CHILD'S NAME: _____

SUBSTANCE USE HISTORY (for ages 12 and older or if applicable)

Substance Type _____ Current Use (last 6 months) Yes ☐ No ☐

Past Use: Yes ☐ No ☐

Please check and complete all that apply:

Substance	Frequency	Amount
Tobacco		
Caffeine		
Alcohol		
Cocaine/ Crack		
Ecstasy		
Heroin		
Inhalants		
Methamphetamines		
Pain Killers		
PCP/ LSD		
Steroids		
Tranquilizers		
Marijuana		

Has your child had withdrawal symptoms when trying to stop using any substances?
Yes ☐ No ☐ If yes, please describe:

Has your child ever had problems with work, relationships, health, the law, etc. due to his/her substance use?
Yes ☐ No ☐ If yes, please describe:

PREVIOUS MENTAL HEALTH TREATMENT

Yes ☐ No ☐
If yes: Dates of Treatment: From _____ To _____

Provider/Program _____

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Type of Treatment:

- ☐ Outpatient Counseling
- ☐ Medication (mental health)
- ☐ Psychiatric Hospitalization
- ☐ Drug/Alcohol Treatment
- ☐ Self-help/Support Groups

Primary Care Physician & Medical Care

Current Physician: _____

Physician Address: _____

Primary Care Physician Phone #: ( ) _____ Fax #: ( ) _____

Emergency Contact:

Medical: _____

MEDICAL INFORMATION

Date of last physical exam: _____
Has your child experienced any of the following medical conditions during his/her lifetime?

☐ Allergies	☐ Asthma	☐ Headaches	☐ Stomach Aches
☐ Chronic Pain	☐ Surgery	☐ Serious Accident	☐ Head injury
☐ Dizziness/fainting	☐ Meningitis	☐ Seizures	☐ Vision problems
☐ High Fevers	☐ Diabetes	☐ Hearing problems	☐ Miscarriage
☐ Sexually Transmitted Disease	☐ Abortion	☐ Sleep Disorder	☐ Other (please list):

Please list any CURRENT health concerns:

Current prescription medications:

Medication Dosage: _____ Date First Prescribed: _____

Prescribed By: _____

Current over-the-counter medications (including vitamins, herbal remedies, etc.):

Please list any allergies and/or adverse reactions to medications:

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SCHOOL INFORMATION

Current grade/placement: _____

This year's school grades:	Excellent	○	Good	○	Fair ○	Poor	○
Past school grades:	Excellent	○	Good	○	Fair ○	Poor	○
This year's school behavior:	Excellent	○	Good	○	Fair ○	Poor	○
Past school behavior:	Excellent	○	Good	○	Fair ○	Poor	○

Has your child had any of the following difficulties at school?

☐ Suspension	☐ Incomplete homework	☐ Learning problems
☐ Referrals or detentions	☐ Poor grades	☐ Teased or picked on
☐ Speech problems	☐ Attendance problems	☐ Gang influence

Does your child have an after-school provider? Yes ○ No ○

If so, who? _____

Has your child ever repeated a grade? Yes ○ No ○
Skipped a grade? Yes ○ No ○

If yes, which one(s)? _____

Has your child ever received Special Education services? Yes ☐ No ☐

If yes, please describe services received and reason for services:

What does your child's teacher(s) say about him/her?

FAMILY AND DEVELOPMENTAL HISTORY

CHILD'S NAME: _____

Include everyone who lives with the child:

Name of Person	**Relation to Child**	**Age of Person**	**Quality of Relationship With Child** *(Good, Fair or Poor)*

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Is there a family history of mental health problems? Yes ☐ No ☐

If yes, who? Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Siblings ☐ Other Relatives ☐

Hyperactivity	☐	Sexual Abuse	☐	Depression	☐
Manic Depression	☐	Suicide	☐	Anxiety	☐
Panic Attacks	☐	Obsessive-Compulsive	☐	Anger/Abusive	☐
Schizophrenia	☐	Eating Disorder	☐	Alcohol Abuse	☐
Drug Abuse	☐		☐		☐

◯ Parents legally married
◯ Living together
◯ Parents divorced
◯ Permanently separated
◯ Parents temporarily
◯ separated

Father remarried: Number of times _____

Mother remarried: Number of times _____

Please check if your child has experienced any of the following types of trauma or loss:

Emotional Abuse	☐	Neglect	☐	Lived (lives) in a Foster Home	☐
Sexual Abuse	☐	Violence in the Home	☐	Multiple Family Moves	☐
Physical Abuse	☐	Crime Victim	☐	Homelessness	☐
Parent Substance Abuse	☐	Parent Illness	☐	Loss of a Loved One	☐
Teen Pregnancy	☐	Placed Child for Adoption	☐	Financial Problems	☐

Were there any medical problems during the pregnancy or birth of your child? Yes ◯ No ◯
If yes, please describe:

Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant with this child? Yes ◯ No ◯

If yes, please describe substances used, quantity, and frequency:

Substance	**Frequency**	**Amount**
Tobacco		
Caffeine		
Alcohol		
Cocaine/ Crack		
Ecstasy		
Heroin		
Inhalants		
Methamphetamines		
Pain Killers		
PCP/ LSD		
Steroids		
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Did your child have any developmental delays in early childhood (crawling, walking, talking, toileting, etc.)? Yes ◯ No ◯ If yes, please describe:

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network (check all that apply):

Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers ☐

Support/Self-Help Group ☐ Community Group ☐

Religious/Spiritual Center (which one?): _____

To which cultural or ethnic group does your child belong? _____

If your child is experiencing any difficulties due to cultural or ethnic issues, please describe:

LEGAL INFORMATION

If the parents are separated or divorced, what is the current child custody/visitation arrangement?

Is your child currently the subject of a custody case? Yes ◯ No ◯

Has your child ever been a ward of the court with DCFS guardianship? Yes ◯ No ◯

Does your child have any legal offenses on record or pending in the courts? Yes ◯ No ◯

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