HDC
Human Development Center
Comprehensive Behavioral Healthcare
Professional. Compassionate. Dedicated.

HDC COMPREHENSIVE EVALUATION INTAKE —AGE 6 AND UP

Thank you for your help in completing this questionnaire about your child. The information is necessary for our clinicians to gain a complete understanding of your concerns. Please let us know if you have any questions.

IDENTIFYING INFORMATION:

Child's Name: _____ **Today's Date**: _____

Preferred Pronouns: She/Her He/Him They/Them **Date of Birth**: _____ **Age**: _____

Self-identified Gender: _____ **Sexual Orientation:** _____

Race: _____ **Ethnicity:** _____ **Primary Language:** _____

Ability to Read/Write? ☐Yes ☐No **Special Accommodations:** _____

Referred By: _____

Reason For Referral/What Is Bringing You In: _____
_____
_____
_____
_____
_____

Current Life Stress Level: ☐High ☐Medium ☐Low

Current Providers *(Provider, provider location, date last seen, reason and frequency of care)*

Primary Care Provider _____
Psychotherapist/CNP _____
Psychotherapist _____
Case Manager _____
ARMHS _____
Probation Officer _____
Other _____

DIMENSION I: Acute Risk or Acute Intoxication/Withdrawal Potential

Risk of Harm

Have you recently had thoughts or wishes to harm yourself? ☐No ☐Yes, _____
Have you recently had thoughts of harming others? ☐No ☐Yes, _____
Do you have a history of self-harm or suicide attempts? ☐No ☐Yes, _____

Substance Use

☐No ☐Yes To your knowledge, does your child currently use any alcohol or illegal substances?
If yes, with what substances, when did they start, and how often used? _____
_____

☐No ☐Yes Has your child ever attended substance abuse disorder treatment?
If yes, where, and when? _____
_____

☐No ☐Yes Does your child have any current or history of substance use withdrawal?
If yes, what symptoms were experienced and when? _____
_____

DIMENSION II: Biomedical and Physical Health History

How would you rate your child's current physical health? ☐Good ☐Fair ☐Poor

Is your child experiencing any physical health concerns or have a current physical health diagnosis? _____
_____

Has your child experienced any of the following? *(Please provide comments):*
Traumatic Brain Injury:_____
Significant Illness That Affects Your Brain or Oxygen Level: _____
Exposure To A Sexually Transmitted or Blood Borne Diseases: _____
Nutritional Concerns: _____
Is your child/could they be pregnant?: _____
Physical Health Disability: _____

Is your child suffering from any physical pain?
☐No concerns with physical pain ☐Acute Pain (Identify Treatment Type Below)
☐Chronic Pain (Identify Treatment Type Below)

If yes, Treatment Type:
☐Prescribed Pain Medication ☐Home Remedies ☐Over the Counter Medication
☐Enrolled in Pain Management Program ☐Physical Therapy
☐Meditation ☐Medical Referral Needed ☐Other, Non-Pharmacological Approach
☐Not Being Treated

Does your family engage in, or want to engage in, any cultural healing practices?☐No ☐Yes, _____

Any Allergies: _____

Current Medications: (Include OTC Medication and/or Herbal Supplements):
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____

Have you been prescribed mental health medications in the past? ☐No ☐Yes
Medication: _____ Dosage: _____ Medication: _____ Dosage: _____

Medication: _____ Dosage: _____ Medication: _____ Dosage: _____

Has your child had any prior surgeries or hospitalizations? ☐No ☐Yes If yes, what, and when?_____

_____

FEMALE CLIENTS: Age of Onset of Menstruation: _____

Additional Comments Regarding Your Child's Current/Past Physical Health:

_____

_____

_____

SUBSTANCE USE HISTORY:

Primary Substance Used	Age of First Use	Most Recent Pattern of Use and Duration:	Date/Time of Last Use	Withdrawal Potential? Needs special care?	Method of Use (Oral, Smoked, Snorted, IV, etc.)
Alcohol					
Amphetamines					
Barbiturates					
Benzodiazepines					
Cannabis					
Cocaine					
Crack					
Hallucinogens					
Heroin					
Inhalants					
Other Opiates/Synthetics					
Methamphetamine					
Nicotine					
Over the Counter Drugs					
Other					

SUBSTANCE USE Withdrawal Symptoms:

Symptom	**Past 12 Months**	**Recent (Past 30 Days)**
Agitation		
Anxiety/Worry		
Confused/Disrupted Speech		
Diarrhea		
Diminished Appetite		
Dizziness		
Fatigue/Extremely Tired		
Fever		
Hallucinations		
Headaches		
High Blood Pressure		
Irritability		
Muscle Aches		
Nausea/Vomiting		

Paranoia		
Psychosis		
Sad/Depressed Feeling		
Seizures		
Sensitivity to Noise		
Shakiness/Jitteriness/Tremors		
Sweating and Rapid Pulse		
Unable to Eat		
Unable to Sleep		
Vivid/Unpleasant Dreams		

Is there anything else you would like us to know regarding your child's substance history or withdrawal symptoms?

_____

_____

_____

DIMENSION III: Emotional/Behavioral/Cognitive

Parent's Marital Status: ☐Married ☐Widowed ☐Divorced ☐Single ☐Partnered ☐Separated

	Name	Age	Occupation
Parent			
Parent			
Stepparent			
Stepparent			

What is the legal and physical custody arrangement?_____

Others Living with Your Child/Siblings Living Outside the Home:

Name	**Age**	**Relationship**	**Occupation/Grade**
Pets:			

Who are the other important people in your child's life (Relatives, mentors, coaches, family friends)? _____

_____

_____

What is your child and family's relationship with extended family? _____

_____

_____

Has your child experienced any significant losses in your family? _____

_____

Does your child have a social support network that would support their recovery efforts? _____

_____

Any developmental incidents? ☐Unremarkable ☐Delayed Milestones ☐Atypical ☐Other _____

EDUCATIONAL HISTORY: Grade Level: _____ School Name: _____
Previous Education/Schools: _____
What has your child's experience been in school? _____
_____
_____
Does your child have behavioral, learning, or social problems at school?
☐No ☐Yes, _____
Does/has your child receive any special educational services (IEP, 504, Title 1) or have special educational needs?
☐No ☐Yes, _____

FAMILY HISTORY: Are there any relatives of the child (including parents, grandparents, aunts, uncles, or cousins who have any of the following conditions?

	Relationship		**Relationship**
ADHD/ADD		Eating Disorders	
Alcohol or Drug Problems		Learning Disorders	
Anxiety/OCD		Mental Health Hospitalizations	
Autism/Autism Spectrum Disorder		Nerve Problems	
Bipolar Disorder		Personality Disorders	
Brain Damage		Physical Abuse	
Chronic Pain		PTSD	
Completion of or Suicide Attempts		Schizophrenia	
Convulsions/Seizures		School Problems	
Dementia		Sexual Abuse	
Depression		Thyroid Problems	
Developmental Delays		Tic/Tourette's Disorder	
Domestic Violence		Other	

PAST MENTAL HEALTH SERVICES:

AHRMS/Case Management Services: _____
CTSS/Case Management Services: _____
Mental Health/Substance Use Hospitalizations: _____
Partial Hospitalization Program: _____
Previous Mental Health Diagnosis: _____
Psychiatric Care:_____
Psychological Testing: _____
Psychotherapy: _____
Other: _____

CHILDHOOD LIFE EVENTS: Below is a list of events that may occur in a child's life. Please check any events that you know or suspect your child has experienced.

X if Yes	Age	Event	Other Information
		Bullying	
		Emotional Abuse	

		Exposure to Adult Substance Use	
		Exposure to Domestic Violence	
		Exposure to Sexual Material	
		Frequent Moves	
		Homelessness	
		House Fire	
		Impaired Parenting (Due to parental mental health issues, substance use, etc)	
		Major Medical Procedure or Surgeries	
		Major Natural Disaster (Flood, tornado)	
		Multiple Separations from Caregiver (Military deployments, working away from home)	
		Other Scary or Dangerous Event	
		Periods of Time When Adults Were Unable to Care for Them	
		Physical Abuse	
		Serious Car Accident	
		Sexual Abuse	
		Sexual Harassment	
		Unexpected Death of a Close Relative	
		Witnessed Others Being Physically Abused	
		Other Traumatic Events	

Comments:_____
_____
_____

CURRENT SYMPTOMS

Please check the follow symptoms you are currently seeing for your child and elaborate on how often and long this has been a problem.

Addictive Behavior

Check if Applies	Symptom	Describe (Include how long and how often)
	Computer/Gaming	
	Exercise/Fitness	
	Gambling	
	Sexual Activity	
	Shopping/Spending	
	Other	

Anxiety

Check if Applies	Symptom	Describe (Include how long and how often)
	Compulsive Behaviors	
	Disorganized Speech	
	Excessive shyness	
	Fearfulness	
	Stomachache/Pain/Headache	
	Intrusive Thoughts	
	On edge/Restless	

	Racing Thoughts	
	Social Fears	
	Unassertive	
	Withdrawn	
	Worries/anxiety	
	Other	

Behavior and Attention

Check if Applies	Symptom	Describe (Include how long and how often)
	Aggressive Behavior	
	Completes Tasks Carelessly	
	Concentration Problems	
	Destroys Own/Others' Possessions	
	Disorganized/Forgetful	
	Distracts/Annoys Others	
	Does Not Notice When They Make Mistakes	
	Focus' Too Much (In their own world)	
	Gets Stuck or Perseverates on Certain Things	
	Has Difficulty Following Directions (School, home, in public)	
	Having Too Much Energy/Cannot Sit Still	
	Impulse Control	
	Lies/Omits Information/Does Not Tell the Truth	
	Mean to Animals	
	Peer/Social Problems	
	Plays with Fire/Matches	
	Poor Judgment About Safety	
	Running Away	
	Takes Things That Do Not Belong to Them	
	Other	

Eating

Check if Applies	Symptom	Describe (Include how long and how often)
	Appetite/Weight Changes	
	Hoards/Hides/Sneaks Food	
	Is dieting	
	Makes Comments About Needing to Lose Weight or Being Fat	
	Other	

Mood

Check if Applies	Symptom	Describe (Include how long and how often)

	Changed Groups of Friends	
	Changed Level of Energy	
	Easily Irritated	
	Hygiene Concerns	
	Lacks Interest in Activities They Use to Enjoy	
	Mood Swings/Emotional lability (Fine one minute, mad/sad the next)	
	Morbid (Talking about death)	
	Negative Thoughts/Beliefs About Self	
	Personality Changes	
	Sadness	
	Seeing, Feeling, Tasting, Smelling or Hearing Things That Are Not There	
	Self-Harming Behavior (Cutting, erasing self, punching walls, etc.)	
	Socially Withdrawn	
	Suicidal Threats	
	Tearfulness/Cries Easily	
	Unusual/Bizarre Ideas	
	Other	

Sleep

Check if Applies	Symptom	Describe (Include how long and how often)
	Difficulty Getting Up	
	Nightmares	
	Problems Falling Asleep	
	Problems Staying Asleep	
	Other	

How many hours of sleep does your child typically get a night? _____
What time is their bedtime during the week? _____ When do they usually get up? _____
Does your child fall asleep by themselves or with someone else? _____

Trauma

Check if Applies	Symptom	Describe (Include how long and how often)
	Avoidance of Memories, Places or People	
	Does Not Appear to Experience Positive Emotions	
	Intrusive Thoughts or Memories	
	Jumpy/Startles Easily	
	Poor Recall or Memory of Events	
	Other	

Are there any other symptoms or issues that you think would be helpful for us to know about?

_____

_____

DIMENSION IV: Readiness for Change

What has helped your child in the past? What has not worked? _____
_____
_____

What would be helpful for you and your child in making changes? _____
_____
_____

DIMENSION V: Relapse, Continue Use/Problem Potential

What would you identify as your child's strengths?

_____
_____
_____

What would you identify as your child's personal challenges?

_____
_____
_____

DIMENSION VI: Recovery Environment

Child's Current Living Situation Any safety concerns in your current living environment? ☐No ☐Yes

Please describe the home in which your child resides *(Include length of residency, household members or status of current housing)* _____
_____
_____

EMPLOYMENT/FINANCIAL

Is your child currently employed or do they have any job history? _____
Any difficulties accessing services or meeting your basic needs:_____
_____
Current Financial Difficulties or Strain: _____
_____

LEGAL

Have you in the past, or are you currently working with Child Protective Services? ☐No ☐Yes
Please provide details on social workers involved, dates of involvement, etc. _____
_____
Has your child been arrested or had any legal interactions? ☐No ☐Yes _____
_____

Is your child currently on probation and/or involved with a specialty court program? ☐No ☐Yes
Please provide details on probations officers name, dates of involvement, etc.
_____

CULTURAL/SPIRITUAL

Do you have any spiritual, or other types of belief systems, that are important to your child's recovery?

_____

_____

Do you have any cultural practices that are important for your child's recovery?

_____

_____

Thank you for taking the time to fill out this questionnaire.