MARIA DROSTE
COUNSELING SERVICES
BRINGING HOPE TO LIFE

Youth History Form

Name of youth	Last		First
	Middle		Preferred/nickname
Address	Street		
	City	State	Zip
Telephone	Cell (if applicable)		Home (if applicable)

All children and teens under the age of 18 years must be accompanied by a parent or guardian to their first visit and must review this form together to the degree that it is age appropriate.

Caregiver 1 (required) Lives with client: ☐	Last name	First name
	Relationship	Phone
	Email (optional)	
Caregiver 2 (optional) Lives with client: ☐	Last name	First name
	Relationship	Phone
	Email (optional)	

Emergency contact

☐ Caregiver 1 ☐ Caregiver 2 ☐ Other:

I, *(Print Name:)*_____ attest that I am the custodial parent or guardian of _____, above named minor, and I authorize my child/teen to participate in therapy at Maria Droste Counseling Services. I agree and understand that while insurance may be billed for psychotherapy services, I am legally responsible for any and all charges incurred in providing this and/or other services by this office. Copies of documentation of legal custody of your child/teen, and any other legal issues pertaining to the child/teen must be provided on or before date of first visit. Copies of these documents will be kept on record.

Unless otherwise noted, your signature indicates that you agree with the following statement: Maria Droste Counseling Services (MDCS) uses your information for our internal statistics to help shape our future programming. Please understand that any data used will remain **completely anonymous**. We will never share you or your child's information with any third parties unless requested by you and in compliance with our policies. We do share aggregate summaries with others for the purposes of outreach and improving our services, which does not include your individual responses to any questions or any identifiable information about you. Please speak with your therapist if you have any questions or concerns about this statement.

_____ _____

CAREGIVER SIGNATURE (CIRCLE ONE: Caregiver1/Caregiver2) DATE

For clinician use only:		
Clinician name:	Client ID (assigned on intake):	☐ Client denied use of information for internal data collection.

Please complete the following questions as they pertain to your child or teen.

GENERAL INFORMATION

Today's date:		DOB		Age	
Race: *(check all that apply)*	☐ American Indian/Alaskan Native ☐ Asian/Asian American ☐ Black/African/African American		☐ Middle Eastern/North African ☐ Native Hawaiian/Pacific Islander ☐ White ☐ _____		
Ethnicity:	☐ Hispanic/Latino(a) ☐ Not Hispanic/Latino(a) ☐ _____				
Language(s):		Annual household income:	☐ Less than $25,000 ☐ $25,000-$49,999 ☐ $50,000-$74,999 ☐ $75,000 or more		
Gender:	☐ Male ☐ Female ☐ _____				
Please list all current members of the child's/teen's household(s) and their ages:					
Does your family currently have DCF involvement?			☐ Yes	☐ No	

HEALTHCARE PROVIDER INFORMATION

What type of health insurance coverage does your child/teen have?	☐ Private ☐ State ☐ Medicare	☐ Medicaid ☐ Employee Assistance (EAP)	☐ Military ☐ I do not have health insurance
Does your child/teen see a pediatrician, psychiatrist, or physician?	☐ Yes ☐ No *If yes, please provide details.*	*Name* *Phone* *Address*	
Has your child/teen ever had any previous mental health counseling?	☐ Yes ☐ No *If yes, please provide details.*	*Therapist/agency, year began, year ended*	
Has your child/teen ever been given a mental health diagnosis or had psychological testing done?	☐ Yes ☐ No *If yes, please provide details.*	*Diagnosis(es), provider(s), major testing results*	

MEDICAL INFORMATION

When did your child/teen have their last medical checkup (estimate if unknown)?			
Does your child/teen have allergies or have they had an allergic reaction to medication(s)?	☐ Yes ☐ No *If yes, please provide details.*	*Allergies*	
Has your child/teen ever had any of the following problems?	☐ Seizure ☐ Head injury ☐ High blood pressure ☐ Heart trouble ☐ Kidney problems	☐ Diabetes ☐ Asthma ☐ Thyroid problems ☐ Liver problems ☐ High cholesterol	☐ Language problems ☐ Vision problems ☐ Hearing problems ☐ _____ ☐ None of the above
Has your child/teen ever had surgery or <u>medical</u> hospitalizations?	☐ Yes ☐ No *If yes, please provide details.*	*Date(s), description*	
Has your child/teen ever been hospitalized for <u>mental health</u> reasons?	☐ Yes ☐ No *If yes, please provide details.*	*Date(s), description*	
Does your child/ teen have any chronic conditions that interfere with their life?	☐ Yes ☐ No *If yes, please provide details.*	How troubled or bothered have they been by these conditions in the past 30 days? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 Not at all Extremely	
Please list any prescription medications your child/teen is currently taking:	*Medication, dose, frequency*	☐ They do not take any medication.	

EDUCATION

Name and location of school		Grade/class year	
Has your child/teen experienced any problems at school?	☐ Behavioral ☐ Academic ☐ Social	*Details:*	
Would you like us to be in contact with the school?	☐ Yes ☐ No *If yes, please provide details.*	*Contact information*	

ALCOHOL AND CHEMICAL USE

Substance *(check all that apply)*	**Type/Amount/Frequency**	**How long? (years)**	**If stopped, when? (yr)**
☐ Caffeine ☐ Tobacco ☐ Alcohol ☐ Marijuana ☐ _____ ☐ _____ ☐ No use			

FAMILY HISTORY

1. Are there any substance use issues in your family? ☐ Yes ☐ No

   If yes, please describe:

2. Does anyone in your family have a history of mental illness? ☐ Yes ☐ No

   If yes, please describe:

SYMPTOMS

To what degree has your child/ teen felt distressed over the past two weeks?	☐ 0 Not at all	☐ 1	☐ 2	☐ 3	☐ 4 Extremely	
To what degree is your child/teen feeling distressed upon entering counseling today?	☐ 0 Not at all	☐ 1	☐ 2	☐ 3	☐ 4 Extremely	
Sometimes things happen to people that are extremely upsetting (ex: being in a life threatening situation like a major disaster, serious car accident or fire; being physically or sexually assaulted; seeing another person go through a trauma such as the ones listed above). At any time during your life, have any of these kinds of things happened to your child/teen or anyone in their family?				☐ Yes (to your child/teen) ☐ Yes (in the family)	☐ No (to your child/teen) ☐ No (in the family)	
What are the major concerns or issues that brings your child/teen to our center?						
Please describe any family information (current or past) that might be helpful: *(e.g. medical issues, deaths in family, divorces/step-parents)*						

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure- Child Age 11-17

Instructions: This section should be completed by your child/teen, if age appropriate. The questions below ask about things that might have bothered you. For each question, select the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

	During the past **TWO (2) WEEKS**, how much (or how often) have you…	**None** None at all	**Slight** Rare, less than 1-2 days	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I	1. Been bothered by stomachaches, headaches, or other aches and pains?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	2. Worried about your health or about getting sick?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
II	3. Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
III	4. Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
IV	5. Had less fun doing things than you used to?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	6. Felt sad or depressed for several hours?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
V & VI	7. Felt more irritated or easily annoyed than usual?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	8. Felt angry or lost your temper?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VII	9. Started lots more projects than usual or done more risky things than usual?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	10. Slept less than usual but still had a lot of energy?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VIII	11. Felt nervous, anxious, or scared?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	12. Not been able to stop worrying?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	13. Not been able to do things you wanted to or should have done, because they made you feel nervous?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
IX	14. Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	15. Had visions when you were completely awake—that is, seen something or someone that no one else could see?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
X	16. Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or someone else?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	17. Felt the need to check on certain things over and over again, like whether the door was locked or whether the stove was turned off?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	18. Worried a lot about things you touched being dirty or having germs or being poisoned?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	19. Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	

	In the past **TWO (2) WEEKS**, have you…		
XI	20. Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No
	21. Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No
	22. Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No
	23. Used any medicine without a doctor's prescription to get high or change the way you feel (e.g. painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No
XII	24. In the last 2 weeks, have you thought about killing yourself or committing suicide?	☐ Yes	☐ No
	25. Have you EVER tried to kill yourself?	☐ Yes	☐ No

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MARIA DROSTE QUALITY OF LIFE SURVEY- YOUTH

Please check the box which best describes how well you are doing at your school:

No problems	Mild problems	Moderate problems	Serious problems	Cannot function	Not working
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ n/a

Please check the box which best describes how well you are doing in your family relationships:

No problems	Mild problems	Moderate problems	Serious problems	Cannot function	Not applicable
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ n/a

Please check the box which best describes how well you are doing with friendships and socializing:

No problems	Mild problems	Moderate problems	Serious problems	Cannot function	Not applicable
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ n/a

Please check the box which best describes how well you are doing taking care of yourself (i.e., keeping up with household chores, managing medical care, being physically active, doing activities or hobbies):

No problems	Mild problems	Moderate problems	Serious problems	Cannot function	Not applicable
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ n/a

Please check the box which best describes your current physical health:

Excellent	Good	Fair	Poor	Very poor
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Please check the box which best describes your general happiness and wellbeing:

Excellent	Good	Fair	Poor	Very poor
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Thank you for taking the time to complete this form.

9/21/2020