Sundstrom
CLINICAL SERVICES

We want to thank you again for reaching out to us and extend a further welcome to Sundstrom Clinical Services. To complete your registration process and to prepare for your initial appointment, please complete the Adult History Form.

PLEASE NOTE: The Child & Adolescent History Form is a fillable PDF form. You need to save a blank copy of the form before completing it to ensure it is filled out correctly:

Instructions

- To save a blank copy: Right click on the form attachment and select "Save link as" and give the file a name. **OR** On the email attachment, click the download button. Once the form appears save a blank copy.
- **This saves a blank copy of the form in one of your folders**.
- Go to your folder and open the file.
- Fill in all grey boxes. All boxed outlines in red are required.
- Save your file.
- Please email completed forms to info@sundstromclinic.com.

If you do not have access to filling in PDF forms you may also print the blank forms, hand write in your answers, and mail them to:

Sundstrom Clinical Services
21900 Willamette Drive, Suite 202
West Linn, OR 97068

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Child & Adolescent History Form

Client's Name: _____ Date of Birth: _____ Age: ___

Preferred Name: _____ Preferred Pronouns: _____

Gender Identity: _____ Sexual Orientation: _____

Cultural / Ethnic / Racial Background: _____

Person completing this form if other than patient: _____ Relation to Patient: _____

Child lives with: ☐ Both parents ☐ Joint parenting ☐ Mother ☐ Father ☐ Other

Name of Primary Care Provider &/or Clinic Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Provider Phone: _____ Provider Fax: _____

May we contact your primary care provider if therapeutically useful? ☐ Yes ☐ No

Are there other Professionals that we may need to contact on behalf of your child?

(Name/Title/Phone): _____

Name of Child's School: _____ Grade: _____ District: _____

Teacher: _____ Counselor:_____

Phone: _____ Fax: _____

How were you referred to Sundstrom Clinical Services? _____

Reasons For Seeking Services

Please describe your concerns and goals:

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SYMPTOMS / ISSUES: Please enter 1-3 for degree of difficulty. (1=minor, 2=moderate, 3=severe, blank=absent)

	Sad / Depressed		Little sleep/ not tired		Disorganized		Lying/ sneaking
	Decreased energy		Withdrawn/ aloof		Memory problems		Fire setting
	Hopelessness		Excessive energy		Difficulty with planning		Blackouts
	Worthlessness		Racing thoughts		Difficulty w/ decisions		Hallucinations
	Loss of enjoyment		Anxiousness		Hyperactivity		Delusions
	Irritability		Uncomfortably socially		Impulsivity		Feel not in your body
	Grief and loss		Panic attacks		Risk taking behavior		Toileting problems
	Guilt		Obsessions		Learning problems		Eating problems
	Loss of enjoyment		Compulsions		Language problems		Eating disorder
	Suicidal thoughts		Perfectionism		Rigid/ inflexible		Abuse victim
	Self-harm		Scared/ fearful		Immature		Abuse perpetrator
	Lack of energy		Resistance to school		Repetitive movements		Trauma history
	Sleep issues		Easily embarrassed		Tics		Substance use
	Appetite changes		Fear of bedtime		Uncoordinated		Pornography issues
	Weight changes		Security blanket/object		Sensory issues		Sexual issues
	Aggressive/ angry		Difficulty concentrating		Peer difficulties		Abortion
	Mood swings		Can't follow directions		Violent		Other:
	Excessive good mood		Can't get started on tasks		Rule breaking		

Please describe any other issues or concerns:

Please describe any actions taken to address symptoms:

Do you have any current mental health diagnoses**?** ☐ Yes ☐ No

If yes, please list your mental health diagnoses:

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Complete if 12 years old or older: Patient Health Questionnaire (PHQ-A): Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling asleep or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself, or that you are a failure or have let yourself or family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching TV	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
Thoughts that you would be better off dead, or of hurting yourself.	☐	☐	☐	☐

In the past year have you felt depressed or sad most days, even if you felt OK sometimes? ☐ Yes ☐ No

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life?

☐ Yes ☐ No

Have you ever, in your whole life, tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

Overall, how satisfied are you with your child's behavior over the last few months:

☐ Very Satisfied ☐ Somewhat Satisfied ☐ Somewhat Dissatisfied ☐ Very Dissatisfied

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Family Demographics

People in your child's family and household(s):

Name	Relationship	Age	Grade/Job:	Guardianship	Live out of home
				☐ Yes	☐ Yes
				☐ Yes	☐ Yes
				☐ Yes	☐ Yes
				☐ Yes	☐ Yes
				☐ Yes	☐ Yes
				☐ Yes	☐ Yes
				☐ Yes	☐ Yes

Additional information:

Parent/gaurdian occupations:

If biological parents are different from above please list below:

Parent 1: _____ ☐ unknown Parent 2: _____ ☐ unknown

If child lives in multiple homes, what are the plan details or custodial arrangements:

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Prior Treatment Or Assessment

Prior Mental Health Treatment: ☐ Yes ☐ No

Please describe any prior outpatient treatment (when, where, therapist's name):

Has your child been hospitalized for psychiatric symptoms: ☐ Yes ☐ No

If yes, please briefly explain:

Prior Testing or Evaluation: ☐ Yes ☐ No

Please describe tests administered, results, diagnoses, conclusions, recommendations, etc.:

Family Background

Family stressors:

- ☐ Death
- ☐ Divorce
- ☐ Health issues
- ☐ Financial difficulties
- ☐ Job Loss
- ☐ Moves
- ☐ Other:

If divorced, parental relationship is:

- ☐ Amicable
- ☐ Minimal communication
- ☐ Conflictual
- ☐ Not in contact
- ☐ High conflict (violence, no-contact order, etc.)
- ☐ Custodial arrangements:

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History of mental health conditions in the following family members:

	Bio Father	Bio Mother	Other Guardians	Siblings	Other Bio Relatives	Others In Home
Substance abuse:	☐	☐	☐	☐	☐	☐
Alcohol abuse:	☐	☐	☐	☐	☐	☐
Depression:	☐	☐	☐	☐	☐	☐
Anxiety/ Panic:	☐	☐	☐	☐	☐	☐
Bipolar:	☐	☐	☐	☐	☐	☐
Moodiness/ Anger	☐	☐	☐	☐	☐	☐
ADHD:	☐	☐	☐	☐	☐	☐
Developmental delays/ MR:	☐	☐	☐	☐	☐	☐
Autistic Spectrum Disorder	☐	☐	☐	☐	☐	☐
Learning disabilities:	☐	☐	☐	☐	☐	☐
Tics/ Tourette's	☐	☐	☐	☐	☐	☐
Psychosis:	☐	☐	☐	☐	☐	☐
Seizures:	☐	☐	☐	☐	☐	☐
Suicide:	☐	☐	☐	☐	☐	☐
Dementia:	☐	☐	☐	☐	☐	☐
Outpatient psychotherapy	☐	☐	☐	☐	☐	☐
Inpatient treatment	☐	☐	☐	☐	☐	☐

Briefly describe pertinent family concerns:

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Briefly describe parent's relationship, sibling relationships, atmosphere in the home, cultural/ ethnic backgrounds, religion, hobbies, activities, etc.:

Do you participate in spiritual activities? ☐ Yes ☐ No Where:

Do you want spirituality to be part of treatment? ☐ Yes ☐ No ☐ Unsure

Developmental Background

Prenatal

Mother's age at birth:

Father's age at birth:

Prenatal care: ☐ Yes ☐ No

☐ Complications

Substance Use: ☐ None

☐ Prescriptions

☐ Alcohol

☐ Caffeine

☐ Tobacco

☐ Recreational drugs

Developmental milestones

	Ave Month	Other
Overall development		
Crawled	☐ 6-9	
Walked 2-3 steps	☐ 9-18	
Followed commands	☐ 12-18	
Single words	☐ 12-24	
2+ word sentences	☐ 24-35	
Toilet trained daytime	☐ 13-36	

Handedness?

☐ Right ☐ Left ☐ Both

Other issues

☐ Poor muscle control

☐ Muscle Tone

☐ Difficulty toileting

☐ Difficulty sleeping

☐ Picky eater

☐ Failure to thrive

☐ Sensory issues

☐ Difficult to soothe

☐ Under responsive

☐ Disconnected socially

Birth History

☐ Vaginal

☐ C-section

☐ Unknown

☐ On time (38-42wks)

☐ Other:

☐ Delivery complications

☐ Adopted (describe below)

Weight at delivery: lbs. oz.

Daily Living

	Independent	Needs help	Causes battles
Dressing/bathing	☐	☐	☐
Eating	☐	☐	☐
Getting food, etc.	☐	☐	☐
Chores/Cleaning	☐	☐	☐

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Birth, Adoption, & Developmental History and Concerns:

Has your child experienced a significant trauma? *(Physical; sexual; emotional; verbal; neglect; exposure to violence, drugs, or sexually explicit material; death; illness; injury; other, etc.)*

Behavioral Background

Social Support

- ☐ Excellent
- ☐ Fair
- ☐ Poor

Prefers peers ages:

- ☐ Younger
- ☐ Older
- ☐ Varies

- ☐ Has best friend/s
- ☐ Poor intimacy with friends
- ☐ Friends are poor influence
- ☐ Few / No friends
- ☐ Little interest in other kids
- ☐ Gets invitations from kids
- ☐ Gets bullied / bullies others
- ☐ Spends night away from home

Extra-curricular/Hobbies:

Behavior & Discipline	**E**ffective	Ineffective	Makes it worse
☐ Loss of Privileges	☐	☐	☐
☐ Grounded from Peers	☐	☐	☐
☐ Grounded: Tech	☐	☐	☐
☐ Do an extra chore	☐	☐	☐
☐ Spanking	☐	☐	☐
☐ Time Out	☐	☐	☐
☐ Other:	☐	☐	☐

Describe any social and behavioral concerns:

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Describe your child's and the family's habits around the usage of technology:

Academic Background

Academic performance:

- ☐ Excellent:
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Best subjects:
- ☐ Worst subjects:
- ☐ Age started school

History of:

- ☐ Upset when leave parents
- ☐ Not wanting to go to school
- ☐ Behavioral outbursts
- ☐ Poor friendships
- ☐ Frequent conflict
- ☐ Bullying
- ☐ Physical complaints
- ☐ Skipping School
- ☐ Grade retention
- ☐ Late/missing work
- ☐ IEP / 504
- ☐ Behavioral supports

GPA (if applicable):

Did your child receive early intervention services: ☐ Yes ☐ No

Briefly describe any academic concerns:

Medical Background

Current physical health:

- ☐ Excellent
- ☐ Fair
- ☐ Poor

Exercise Regularly?

☐ Yes ☐ No

Medical history of:

- ☐ Allergies (list below)
- ☐ Accidents
- ☐ Surgeries/hospitalizations
- ☐ Stomach aches
- ☐ Headaches
- ☐ Constipation
- ☐ Pain
- ☐ Neurologic condition (e.g. seizures, head injury
- ☐ Endocrine condition (e.g diabetes, thyroid, PCOS)
- ☐ GI condition (e.g., chron's, UC, IBD, GERD)
- ☐ Genetic condition (e.g., sickle cell, PKU)
- ☐ Other:

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Please list known allergies and briefly describe any pain or chronic health conditions, or describe any significant medical history and concerns:

Please list any current physical health diagnoses and any treatment you may have had or are receiving for your health condition:

Sleep: Average hours of sleep: Time to bed: Time wake:

Overall sleep quality:
- ☐ Excellent
- ☐ Fair
- ☐ Poor

- ☐ Snoring
- ☐ Sleep walking
- ☐ Nightmares/terrors
- ☐ Afraid to sleep alone

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Early morning waking
- ☐ Bedtime behavior problems

- ☐ Restless sleeper
- ☐ Other:

Eating: ☐ Eats too little ☐ Eats too much ☐ Picky ☐ Strong aversion to textures

Has your child had a recent significant**:** ☐ Weight loss lbs. ☐ Weight gain lbs.

Has your child seen any medical provider (MD, NP, DO, or specialist) within the past year: ☐ Yes ☐ No

Please list all mental health medications your child is **currently taking**, name and dose, and a brief explanation of how they are working: ☐ None

Please list all mental health medications your child has **previously tried**, name and dose, and a brief explanation of how you responded: ☐ None

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Please list all other medications (prescribed or over the counter) you are **currently taking**, name and dose, and a brief explanation of what they are for: ☐ None

Please provide any information on why medications were discontinued or any adverse side effects:

Does your child follow their medication regime? ☐ Yes ☐ No

If no, please explain:

Please describe any other significant medical history and concerns:

What do you see as your child's strengths?

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Areas of Risk

To your knowledge, has your child ever reported any of the following? Does not apply

Feelings of hopelessness	☐ Never	☐ Past	☐ Present
Wish to not be here/ end distress	☐ Never	☐ Past	☐ Present
Thoughts of harming self	☐ Never	☐ Past	☐ Present
Self-harm actions (e.g., cutting, mutilation)	☐ Never	☐ Past	☐ Present
Suicidal Attempts	☐ Never	☐ Past	☐ Present
Wish to harm others	☐ Never	☐ Past	☐ Present

Never	Past	Present	
☐	☐	☐	Severe feelings of hopelessness
☐	☐	☐	Wish to not be alive or end distress
☐	☐	☐	Thoughts of harming self
☐	☐	☐	Actions to harm self (e.g., cutting, mutilation)
☐	☐	☐	Suicidal attempts
☐	☐	☐	Wish to seriously harm others

To your knowledge, does your child consume these substances: (*Please include frequency/amount*): ☐ N/A

	Current	Suspected	Past	No
Caffeine	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Prescription meds	☐	☐	☐	☐
Illegal/ recreational substances	☐	☐	☐	☐
Other:				

Please describe any prior treatment: