Headway
Emotional Health

Day Treatment Application Determination Form

Client Information:

Adolescent Name:_____ Date of Birth:_____

Age:_____ Gender: ☐ Male ☐ Female ☐ Other:_____ Grade:_____

Ethnicity origin (or Race): Please specify your child's ethnicity. (Check all that apply)

☐White
☐Hispanic or Latino
☐Black or African American
☐Native American or American Indian
☐Asian / Pacific Islander
☐Other:_____

Name of person completing form:_____ Relationship to adolescent:_____

Who referred your adolescent?_____

Please give a brief description of why you are seeking treatment for your adolescent:_____

_____

Family Information:

Mother's Name:_____ Age:_____ Education Level:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email:_____

Relationship to adolescent: ☐ Natural Parent ☐ Step-Parent ☐ Adoptive Parent ☐ Foster Parent

*Marital Status: _____ Adolescent primarily lives here ☐

Father's Name:_____ Age:_____ Education Level:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email:_____

Relationship to adolescent: ☐ Natural Parent ☐ Step-Parent ☐ Adoptive Parent ☐ Foster Parent

*Marital Status: _____ Adolescent primarily lives here ☐

If divorced, a copy of the most recent* ***Court Documents/Divorce Decree is mandatory*

Family Information (Continued):

Is the adolescent adopted? ☐ Yes ☐ No If yes, specify country of origin:_____

Age when adolescent was first in home:_____ Date of legal adoption:_____

Adolescent currently lives with/for how long:_____

If parent's are separated or divorced, who has custody of this adolescent?:_____

Dates of adolescent's parents' marriage, separation(s) and/or divorce:_____

Comments about custody/visitation:_____

Do any other adults live in the home? ☐ Yes ☐ No

If yes, please list Name/age/relationship to the adolescent:_____

_____

How many children are living in the home? _____ Please list Name/Age/Relationship to the Adolescent:

Name: _____ Age: _____ Relationship_____

Name: _____ Age: _____ Relationship_____

Name: _____ Age: _____ Relationship _____

Name: _____ Age: _____ Relationship _____

Name: _____ Age: _____ Relationship _____

Name: _____ Age: _____ Relationship _____

Abuse & Support Services History:

Has your adolescent ever been abused? ☐ Yes ☐ No

If yes, please circle: Physically Emotionally Sexually By ways of neglect

Has your adolescent ever witnessed somebody else being abused or hurt?_____

If yes, please explain:_____

What major stresses or changes have occurred in your adolescent's life? _____

_____

Who does your adolescent regard as the most supportive in their life (specific family members, teacher, coach, friends, pets, etc.)?

_____

List any involvement with social services, child protection, the court system or legal services:_____

_____

Developmental History:

Pregnancy:

Did the adolescent's mother receive prenatal care during the pregnancy?

☐ Yes, starting in which month?_____ ☐ No

Mother's age during this pregnancy:_____

Number of the following mother has had:

Pregnancies _____ Miscarriages _____ Premature Births _____

Were there any problems in pregnancy, labor, birth or delivery with this adolescent? ☐ Yes ☐ No

If yes, please give details:

_____

_____

Did mother have any of the following during or immediately before/after the pregnancy?

Maternal injury. Describe:_____

Hospitalization during pregnancy. Reason:_____

X-rays during pregnancy. What month?_____

Were any of the following used in pregnancy? (Circle all that apply):

Tobacco	Marijuana	Methamphetamines
Amphetamines	Heroin	Methadone
Cocaine	Alcohol	Other (specify): _____

Development:

During the adolescent's first 3 years, were there any special problems noted in the following areas?

☐ Irritability
☐ Difficulty sleeping/feeding
☐ Failure to thrive/very poor weight gain
☐ Convulsions/twitching/seizures
☐ Unable to separate from parent
☐ Breathing problems
☐ Temper tantrums
☐ Excessive crying
☐ Early learning problems
☐ Other _____
☐ Colic
☐ Poor eye contact
☐ Withdrawn behavior
☐ Destructive behavior

Medical History/Previous Mental Health Treatment:

Primary Care Clinic _____ Physician:_____

Do we have your permission to contact your adolescent's primary care physician to assist with coordination of your adolescent's care: ☐ Yes ☐ No

Date of last medical examination:_____

List any current medical problems:_____

List any hospitalizations or serious medical problems:_____

List any medications currently taking:_____

_____

List any previous medications taken and their effectiveness:_____

_____

List any drug allergies:_____

List any other allergies:_____

Does your adolescent use any over-the-counter medications regularly/frequently?_____

Does your adolescent have any communicable diseases? ☐ Yes ☐ No

If yes, please list: _____

Describe any family history of mental health or chemical dependency problems or treatment: _____

_____

_____

List any counselors your adolescent has seen in the past and reason(s) for visits:_____

_____

_____

List dates of any psychiatric hospitalizations:_____

Date of last appointment with Psychiatrist or Psychologist:_____

Chemical Use History

Please check any that apply to your adolescent's non-prescribed drug or alcohol usage:

Drug Name	Use Currently	Within last 12 months	Have used in the past	Never
Cannabis - Marijuana, Hash				
Alcohol				
Amphetamines - Speed, Cocaine, Crack, Crank, Dexedrine, White Crosses, Ritalin, Cylert, etc.				
Tranquilizers - Valium, Xanax, Ativan, Librium, Sleeping Pills, Seconal, Quaaludes, etc.				
Narcotics - Codeine, Percodan, Darvon, Demerol, Morphine, Heroin, Methadone, Talwin, etc.				
Other - Inhalants, PCP, LSD, Mushrooms, Paint Thinner, Nitrite "Poppers", etc.				

Has your adolescent used more than one chemical at the same time in order to get high? ☐ Yes ☐ No

Does your adolescent avoid family activities so he/she can use? ☐ Yes ☐ No

Does your adolescent have a group of friends who also use? ☐ Yes ☐ No

Does your adolescent use to improve his/her emotions such as when he/she feels sad or depressed? ☐ Yes ☐ No

Does your adolescent use tobacco products? If yes, type? _____

Quantity per day: _____

Does your adolescent use caffeine? If yes, type? _____

Quantity per day: _____

Please list any concerns in the following areas, comment briefly, and rate them as indicated:	Severity			
	No Concerns	Mild	Moderate	Severe
Social Skills and interactions and relationships with peers:				
Social Skills and interactions and relationships with family members:				
Communication and language:				
Behavior and self-regulation:				
School work and learning:				
Emotional concerns:				
Self-esteem:				
Dietary/Nutrition:				
Medical (i.e. seizures, allergies, gastrointestinal or other):				
Other:				

Educational History:

Name of current school _____

Has your adolescent ever repeated a grade? ☐ Yes ☐No Reason _____

If yes, what grade _____

Does your adolescent like going to school? ☐Yes ☐No Reason_____

Has your child ever been suspended or expelled? ☐Yes ☐No Reason_____

Is your adolescent absent from school frequently? ☐Yes ☐No Reason _____

Is your child on an IEP (Individual Education Plan) or a 504 Plan? ☐Yes ☐ No

If yes, for what reason? _____

Special Classes/Services: Please check all that apply (specify what grade/frequency/duration)

☐ Specific Learning Disability (SLD) _____

☐ Emotional/Behavioral Disability (EBD) _____

☐ Autism Spectrum Disorder (ASD) _____

☐ Speech/Language Impairment (SLI) _____

☐ Cognitive Disability (CD) _____

☐ Occupational Therapy (OT) _____

☐ Physical Therapy (PT) _____

☐ Adaptive Physical Education (APE) _____

☐ Other _____

If your adolescent is in school please comment on the areas below:	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
Overall school performance					
Reading					
Writing					
Mathematics					
Relationship with teachers					
Relationship with peers					

Other Helpful Information:

What are the strengths of your adolescent?

_____

_____

_____

Does your adolescent have a Job or involved in extracurricular activities? If so, please list:

_____

_____

Is spirituality and/or faith system important to your family? To your adolescent?

_____

_____

Additional comments: _____

_____

_____

_____

Date Application was completed:_____