HEGIRA PROGRAMS, INC.

PARENT/GUARDIAN
PSYCHO-SOCIAL SELF REPORT RECORD

Child's Name:______________________________ Child's Age: ________ ID #: ____________________

Person Completing Form: ____________________________ Relationship to Child: ____________________

Check all the problems this child is having or has had by placing an "X" in the "Current" and/or "Past" column.

	Current	Past
Gets angry easily		
Temper tantrums		
Yells and screams		
Hits children or adults		
Throws/breaks things		
Threatens to hurt others		
Shows no respect; argues		
Gets into a lot of fights		
Won't follow rules/do chores		
Won't do what adults say to do		
Lies		
Steals		
Cheats		
Is never sorry		
Sets fires		
Hurts animals		
Skips/doesn't want to go to school		
Runs away		
Has friends who are a bad influence		
Problems making/keeping friends		
Worries a lot/nervous		
Sad/depressed		
Quick changes in mood		
Hard time falling asleep		
Sleeps during the day		
Won't sleep in own bed		
Nightmares		
Afraid/fearful		
Irritable		
Problems being away from caregiver		
Stays away from people, friends, or activities		
Shy		
Low self-esteem		
Lots of headaches or stomach aches		
Overeating		
Loss of appetite		
Doesn't keep self clean/won't bathe		
Recent weight loss		
Recent weight gain		
Eats a lot in a short amount of time		

	Current	Past
Forces self to vomit		
Tobacco use		
Drug or alcohol use		
Sexually active		
Masturbates		
Acts in a sexual way that is not appropriate		
Gang member		
Does things in secret/hides		
Does things that are dangerous		
Acts before thinking		
Pays attention for only a short time		
Hard time concentrating		
Forgets things		
Unable to sit still		
Overactive		
Underactive		
Keeps to him/herself		
Has imaginary friends		
Doesn't trust others		
Too trusting of others		
Can't take mind off one subject		
Likes order and routine		
Twitches, jerks, or shakes		
Grinds teeth		
Sucks thumb		
Bites nails		
Picks skin		
Hits self		
Bangs head		
Hurts/cuts self		
Below average intelligence		
Problems with talking/speech		
Grunts, barks, snorts, or growls		
Wets pants/clothes		
Wets bed		
Soils clothes		
Smears feces		
Hears voices that are not there		
Sees things that are not there		
Other:		

Does this child have thoughts of hurting herself/himself or others? ☐No ☐Yes - If Yes, when and how?

____

____

Has this child attempted to hurt herself/himself or others? ☐ No ☐ Yes - If Yes, when and how?

____

____

Why do you think this child is having these problems? ______________________

____

____

Have there been new changes or pressures in your or this child's life? ☐ No ☐ Yes ____________

If yes, explain: ______________________________________

____

What do you want this child to gain from treatment? ______________________

____

____

Does this child have any (physical, learning, or thinking disability, limitation, or impairment) that may tell us if he/she can be an active part of treatment? ☐ No ☐ Yes If Yes, explain: ____________

What strengths does this child have? ______________________________

PRENATAL AND BIRTH HISTORY

Mother's age at child's birth: __________

During pregnancy was there any use of: ☐ Tobacco ☐ Alcohol Other drug(s): ____________

Prescription medication: ______________________

Check if any of the following happened during pregnancy: ☐ Vomiting ☐ Spotting ☐ Kidney trouble

☐ Excess swelling ☐ High blood pressure Other ____________________

Was the pregnancy full term? ☐ Yes ☐ No # of weeks: _______ Birth weight: ___________

Check if any of the following happened:

☐ C-Section ☐ Breech birth ☐ Jaundice ☐ Use of delivery instruments (for example, forceps)

Other problems ______________________________________

Tell about any feelings of depression (sadness) the mother had during pregnancy and/or after delivery:

____

____

INFANT AND TODDLER HISTORY

Tell about the way this child acted from birth to age 2: ______________________

____

____

Tell about the way this child acted from ages 2 to 5: ______________________

____

____

As an infant or young child, check if he/she had problems with:

☐ Becoming attached to parent/caregiver ☐ Being away from caregiver ☐ Energy
☐ Growth ☐ Asthma ☐ Allergies ☐ Vomiting ☐ Fever ☐ Colic ☐ Diarrhea ☐ Constipation
☐ Sleep ☐ Seizures ☐ Eating Other: ______________________

At what age did this child: Walk ________ Speak single words __________ Speak sentences ___________

Become toilet trained: Daytime __________ Nighttime _________

If there were/are problems with any of these, what were they? ______________________________________

FAMILY INFORMATION

Child raised by: ____

List other adults who are important to this child: ____

Is this child adopted? ☐ No ☐ Yes If Yes, does this child know? ☐ No ☐ Yes

If parents are separated/divorced/or never married - parent custody/visitation arrangements*: _____________

____

*A copy of the court guardianship/custody legal papers are necessary for our file in separation/divorce cases.

Which parent knows that this child may be treated here? ☐ Mother ☐ Father

Has this child ever been in foster care? ☐ No ☐ Yes - If Yes, when and why? __________________________

____

Has this child/family ever been seen or talked to by someone at DHS? ☐ No ☐ Yes If yes, explain: _______

____

Has Protective Services ever talked with or seen this child or this child's family? ☐ No ☐ Yes

If Yes, when and why? ____

____

Describe any violence, physical abuse, or sexual abuse that the child has seen, heard, been a part of, or had happen to him/her:

☐ None ____

Do you/family member/guardian have any sexual or gender (boy/girl) concerns about this child? ☐ No ☐ Yes

If yes, why? ____

____

Is there anything going on in the family that may be affecting this child at this time? ☐ None _____________

____

____

List this child's relatives with mental health and/or substance abuse problems: __________________________

____

Annual Household Income: $____________

Sources of Income: ☐ Employment ☐ DHS/Public Assistance ☐ Social Security or Disability
☐ Child Support/Alimony ☐ Retirement Other: ______________________________

Father's Occupation: ☐ Unemployed

Mother's Occupation: __________________________________ ☐ Unemployed

Do you/family currently have money problems? ☐No ☐Yes If Yes, explain: ________________________

____

How is this child disciplined?

Mother: ____

Father: ____

Other: ____

Tell us about this child's religious/spiritual upbringing: _______________________________________

____

Tell about your family's ethnic background (traditions, language, holidays): ______________________

____

EDUCATIONAL/SCHOOL HISTORY

Has this child gone to: ☐ Preschool ☐ Day Care ☐ Latch Key Program

Has this child been diagnosed as having learning problems (learning disabled, emotionally impaired, or mentally retarded)? ☐ No ☐ Yes If Yes, please describe:

____

____

Has this child had any psychological testing done at school or at another clinic? ☐ No ☐ Yes

If Yes, where? ___________________________________ when? _____________________________

Do you know if a diagnosis or name of a condition was given to this child by a doctor, psychologist, or social worker? ☐ No ☐ Yes

If Yes, what was it? ____

____

How are the child's grades in school?

☐ Unsatisfactory ☐ Satisfactory ☐ Passing Mostly: ☐ A ☐ B ☐ C ☐ D ☐ Failing

Tell about any school problems (attendance, suspensions, behavior, not completing homework, failing a grade:

____

Fill in the names and cities of all schools this child has gone to:

Elementary School ____

Middle School ____

High School ____

How many friends does this child have? _____ Are the child's friends: ☐ Same age ☐ Older ☐ Younger

Is it hard for this child to make or keep friends? ☐ No ☐ Yes If Yes, why: ______________________________

____

Father's Educational Level: ☐ Post College/Advance Degree ☐College Graduate
☐ High School Graduate ☐ Some High School ☐ 8th Grade or Less

Mother's Educational Level: ☐ Post College/Advance Degree ☐College Graduate
☐ High School Graduate ☐ Some High School ☐ 8th Grade or Less

TREATMENT/COUNSELING HISTORY

Has this child ever met with a social worker at school? ☐ No ☐ Yes If Yes, when? ______________________

Has this child ever been in treatment for mental health or substance abuse problems? ☐ No ☐ Yes

If yes, please list where, when, reason, and if it helped:

Where	When	Reason	Helpful?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Any other comments you would like to make about this child: ______________________________________

____

____

____

____

______________________________________ ______________________________
(Custodial) Parent/Guardian Signature Date

______________________________________ ______________________________
Signature and Credentials of Therapist reviewing this form Date