Youth Home Resident Demo Sheet

DATE: _____ Arrival Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Social Security#: _____ Gender: M / F

Home Address: _____ Telephone #: _____

Grade in School: _____ Last School Attended: _____

Special Ed: Y/N Emotional Impairment or Learning Disability

Race: _____ Eye Color: _____ Hair Color: _____

Identifying Marks/Tattoos: Y/N Where: _____

Piercings: Y/N Where: _____

Self-Mutilation: Y / N How many yrs: _____ Last Time Cutting: _____

Placement Facility: _____ Length of Placement: _____

Reason for placement: _____

Probation Charges: _____ Other Legal Hx: _____

Referral Contact (DHS/PO/Foster): _____

Referring County: _____ Address: _____

Telephone#: _____ Fax #: _____

Email: _____

GUARDIAN INFORMATION

Mother: _____ DOB: _____ Rights/Visitation Y N

Address: _____ Telephone#: _____

Father: _____ DOB: _____ Rights/Visitation Y N

Address: _____ Telephone#: _____

Are Parents living together? Yes or No Married Divorced or Cohabitant

Step Parents: _____

Primary Guardian: _____ DOB: _____

Address: _____ Telephone#: _____

Is Primary Guardian Biological or Adoptive or Court Appointed?

PAST PLACEMENT

Past Residential Placement: _____

Where/Year/Duration: _____

Past Juvenile Detention: _____

Where/Year/Duration: _____

Psych Hospital Placement: _____

Where/Year/Duration: _____

Total Foster Family Placement: _____

City/Year/Duration: _____

Eye Exam in last 2 years: Y or N Dental Exam in last Year: Y or N Orthodontist Services: Y or N

MCIR Updated: _____ PE Last Completed: _____ Date of Last Labs: _____

Mental Health and Medical Records accompany client: Y or N

Medical Release of Information: Y or N

Recent Hospitalizations: _____

Recent Injuries or Illness: _____

RESIDENT INFORMATION

Name: Date of Birth:

Ht: WT: BP: HR: Resp: Temp: O2 sat

Visual Acuity: OU: OS: OD: Corrected: Y/N Wears Corrective Lens: Y/N

MENSTRUAL HISTORY - female

Age Onset Period:_____ LMP:_____ Pregnancy Hx: G P M A

DEVELOPMENTAL HISTORY

Problematic Pregnancy? Y or N Fetal exposure to alcohol & drugs? Y or N

Problems during Delivery? Y or N Gestational age at delivery:_____

Neonatal or Infantile Illness: Y or N

Were there family moves, separation, family member loss, or abuse during the first 2 years of life? Y or N

Developmental Milestone Achievement: Delayed Normal Accelerated

Age of achievement: Smiling_____ Sitting up_____ Walking_____

Single Words_____ Two Words_____ Complete sentence_____

PAST MEDICAL HISTORY

Asthma	Diabetes	HTN	HLD	Thyroid	Cardiac	Seizure	TBI	Cancer	MRSA
STD	HVB/HVC	HIV	Cancer	Ocular	Dental	Orthopedic	Derm	CKD	
Other:									

FAMILY HISTORY

M: Mother F: Father S: Sibling PGP: Paternal Grandparent MGP: Maternal Grandparent O: Other

DM	HTN/HLD	CAD/CVA	CKD	Cancer	Blood Dz	Liver Dz	Depression	Bipolar	Schizophrenia

Alcoholism	Prescription Drug abuse	Recreational Drug abuse	Mental Retardation	Anxiety	ADHD	OCD	Autism Aspergers	Genetic Disorder	Suicide Attempt

SURGICAL HISTORY

Appendectomy	Tonsillectomy	Ear Tubes	Cardiac	Kidney	Gastro-Intestinal	GYN	Circumcision	Hernia
Orthopedic	C sec	Ocular	Other:					

PSYCHIATRIC HISTORY

Date Last Psych Assessment: Date of last Psychiatric Evaluation:

Current Provider of Meds: Past Counseling Services: Y or N

Past Psychiatric Medication & Effects:

History of Suicidal Attempt: Y or N Mechanism of Attempt:

History of physical mental or sexual abuse: Y or N

History of criminal sexual conduct: Y or N

History of Violent Crime: Y or N

SOCIAL HISTORY

Residential Guardian/City: Home/Apt/Shared Living Arrangements

State Ward: Y or N

Brothers – Name/Age:

Sisters – Name/Age:

Sexual Active: Y or N Total partners: Protection: Y/N Children:

Sexual Orientation: Hetersexual Homosexual Bisexual

Religious Status:

SUBSTANCE ABUSE HISTORY

ETOH Use: Y or N Rec Drug: THC Cocaine Heroin Meth MDMA PCP Smoking Snorting IVD

Prescription RX:

Tobacco Use: Y or N yrs: IVDA: Y or N Duration/Type: Huff: Y or N

REVIEW OF SYMPTOMS

General SX	Bipolar	Depression	ADHD
Nausea/Vomiting	Mood Liability or Cycling	Depressed Mood	Poor judgment
Diarrhea/Constipation	Easy of Agitation Irritation	Difficulty Falling Asleep or Awakening	Distraction
Abd Pain / Cramps	Lots of Energy	Nightmares Freq Awakenings	Hyperactive
Loss of Appetite	Too Much Sleep Insomnia	Excessive Guilt Random Crying	Limited Concentration
Increased Appetite	Racing Jumbled Thoughts	Isolative Difficulty Enjoying oneself	Limited Attention
Encopresis Fecal Smear	Poor Concentration	Tired Low Energy Low Motivation	**Impulsivity**
Enuresis Day / Night	Fast Loud Speech	Self-Harm behavior Past Suicide Attempt	Explosive Anger
UTI/Auria/Hematuria	Interruptive Intrusive	Hopelessness Worthlessness	Non-remitting Rage
Palpitations / CP	Unachievable Goals	Aggression to ward others	Interruptive
Dyspnea	Inflated Self-Esteem	**Anxiety**	Verbal & Physical Outburst
Syncope Dizziness	Grandiose Thinking	Excessive worry Muscle Tension	Lying, stealing, spending, Running
Headache Fever Chills	Acting out of Character	Restlessness Feeling on Edge	
Staring/Seizure	Hypersexual	Panic Attacks Specific Fears	**Obsessive-Compulsive**
Rash	Inappropriate Social Acting	Fear of going to certain place	Repetitive unwanted thoughts
Arthralgia/Myalgia	Lack of Fear or punishment	Fear of Embarrassment	Repetitive Behaviors without ability to suppress or stop
Tremor Gait Disturbance	Excessive Inhibited Actions	**PTSD**	Trichotillomania
Slurred Speech	**Oppositional**	Experienced a Traumatic Event	
Body Stiffness	Negative Hostile	Distressing Nightmares or Memories	
Tics: Facial, Motor, Vocal	Often loss of Temper	Avoid situations of negative reminders	Homicidal Ideation
Learning Disability	Defiant	Numb and Detached	Suicidal Ideation
Binge or Purging		Always on Guarded Ease to Startled	Hallucinations Visual or Auditory
Clueless with Social Situations		Victim of Physical or Sexual Abuse	

Circle the above Symptoms that you are currently struggling with.

ALLERGIES

NKMA PNC Sulfa Latex Codeine Environmental Foods

Other: _____

CURRENT MEDICATION

Medication	MG Strength	Daily Frequency	Last Refill	Intake Count of Pills

Medication Change in last 90 days: Y / N

What was adjusted: _____

What problems have brought you to this facility? _____

What stressful circumstances have contributed to your placement and/or emotional distress? _____

What do you wish the medication could help you with? _____

What do you hope to learn from the program? _____

What do you need to work on in the program to better yourself? _____

What do you need help with to be successful in the program and your future? _____

Do you have hope that your situation will become better? _____