TEXAS DEPARTMENT OF HEALTH
ADOLESCENT INITIAL HISTORY FORM
(11-21 YEARS)

Today's Date: _____

Name: _____

Date of Birth: _____ Age: _____

Gender: ○M ○F

****Please answer all questions on this form in reference to the teenage patient.**

- 1st Parent/Guardian Name: _____ Relationship: _____ Phone #: _____
  2nd Parent/Guardian Name: _____ Relationship: _____ Phone #: _____
- Who brought you to clinic today? _____
- Are you in school? ○ Yes ○ No Name: _____ Grade _____
- Do you have a job? If so, where do you work? _____

Medical History:

1. Do you have any health problems? ..... ○ Yes ○ No

Problems: _____

2. Have you ever been hospitalized for an illness or had an operation? ..... ○ Yes ○ No

If yes, give age and explain the reason for hospitalization or operation:

Age _____ Reason: _____
Age _____ Reason: _____
Age _____ Reason: _____

3. Have you had any serious injuries? ..... ○ Yes ○ No

If yes, give age and describe the injury:

Age _____ Injury: _____
Age _____ Injury: _____

4. Do you take any medications regularly? ..... ○ Yes ○ No

Medication	How long	Reason

5. Do you have any allergies to medicines? ..... ○ Yes ○ No

Name of medicine: _____ Type of reaction: _____
Name of medicine: _____ Type of reaction: _____

6. If you ever had any of the following problems, please write how old you were when it started:

	Yes	No	Age		Yes	No	Age
Acne	○	○	____	Depression	○	○	____
Asthma	○	○	____	Emotional problems	○	○	____
Bladder infection	○	○	____	Learning problems	○	○	____
Tuberculosis	○	○	____	Sickle cell anemia or trait	○	○	____
Chicken pox	○	○	____	Stomach ulcer	○	○	____
Mononucleosis	○	○	____	Heart disease	○	○	____
Hepatitis	○	○	____	Diabetes	○	○	____
STD's	○	○	____	Thyroid	○	○	____
Headaches	○	○	____	Cancer	○	○	____
Seizures/epilepsy	○	○	____	Scoliosis/back problems	○	○	____
Vision	○	○	____	Other: _____	○	○	____
Hearing problems	○	○	____	Other: _____	○	○	____

7. Specific Health Concerns:

Please check below if you have any questions or concerns about any of the following:

☐ Height	☐ Chest pain	☐ Learning or school problems
☐ Blood pressure	☐ Coughing/wheezing	☐ Muscle or joint pain
☐ Acne	☐ Wetting the bed	☐ Cancer
☐ Breasts	☐ Frequent or painful urination	☐ Dying
☐ Heart	☐ Headaches	☐ Menstruation/periods
☐ Appetite	☐ Trouble sleeping	☐ Pregnancy
☐ Stomach pain	☐ Tiredness	☐ Sexual organs/genitals
☐ Nausea/vomiting	☐ Vision problems	☐ Physical or sexual abuse
☐ Diarrhea/constipation	☐ Hearing problems	☐ Other: _____

8. Family Information:

Please check if anyone in your family (including grandparents, aunts, uncles, cousins, etc.) Have or had any of the following problems:

Yes	No	Relationship	Yes	No	Relationship
○	○ Cancer	_____	○	○ Drug abuse	_____
○	○ Heart attack (<55 yrs)	_____	○	○ Mental illness	_____
○	○ High blood pressure	_____	○	○ Learning problems	_____
○	○ Diabetes	_____	○	○ Tuberculosis	_____
○	○ Alcoholic	_____	○	○ Stroke	_____

9. With whom do you live? _____

Do you have any family problems? ○ Yes ○ No

If yes, explain: _____

10. During the past year have there been any of the following changes in your family:

☐ Marriage ☐ Serious illness ☐ Births ☐ Deaths

☐ Separation ☐ Divorce ☐ Loss of job ☐ Other: _____

11. Patient's father/guardian's job: _____ **Patient's mother/guardian's job:** _____

12. Have you ever lived away from home? ○ Yes ○ No

If yes, explain: _____

13. Form filled out by: ○ patient ○ guardian/parent ○ other:

Please complete this page for patients 12 years and older only

Date of Birth:_____

Name:_____ **Age:** _____ **Sex: Male** ○ **Female** ○ **Date:**_____

Instructions: How often have you been bothered by each of the following symptoms during the past **7 days**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

						Clinician Use
						Item score
		(0) Not at all	**(1) Several days**	**(2) More than half the days**	**(3) Nearly every day**	
1.	Feeling down, depressed, irritable, or hopeless?	○	○	○	○	
2.	Little interest or pleasure in doing things?	○	○	○	○	
3.	Trouble falling asleep, staying asleep, or sleeping too much?	○	○	○	○	
4.	Poor appetite, weight loss, or overeating?	○	○	○	○	
5.	Feeling tired, or having little energy?	○	○	○	○	
6.	Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?	○	○	○	○	
7.	Trouble concentrating on things like school work, reading, or watching TV?	○	○	○	○	
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?	○	○	○	○	
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?	○	○	○	○	
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if 1-2 items left unanswered)	

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes

CRAAFT SCREENING TEST (96160)

1. Have you ever ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs?.....YES ○ NO ○
2. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?.....YES ○ NO ○
3. Do you ever use alcohol or drugs while you are by yourself, alone?.....YES ○ NO ○
4. Do you ever forget things you did while using alcohol or drugs?.....YES ○ NO ○
5. Do your family or friends ever tell you that you should cut down on your drinking or drug use?.....YES ○ NO ○
6. Have you ever gotten into trouble while you were using alcohol or drugs?.....YES ○ NO ○