Pre-Assessment

SFCR PSYCHIATRIC TREATMENT HISTORY

Is your child currently receiving any mental health treatment? YES NO

If yes:

1. Where is your child in treatment now? _____
2. When did they start services with this provider? _____

List any and all previous psychiatric treatment <u>your child</u> has received:

Age	Dates of Treatment	Symptoms or Condition	Treatment/Location
	to		
	to		
	to		
	to		
	to		

Age at first outpatient treatment _____

Age at first psychiatric hospitalization _____

Number of psychiatric hospitalizations _____

Psychotropic medications

List all medications your child is <u>currently</u> taking for psychiatric purposes:

Medication Name	Type of Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Post-Assessment

SFCR PSYCHIATRIC TREATMENT HISTORY - UPDATED

Date of Pre-Assessment: _____

While participating in Strengthening Family Coping Resources, did your child receive any other mental health treatment? YES NO

If yes:

1. Where was your child being treated? _____
2. Dates of treatment: _____ to _____
3. What type of services did your child receive (circle all that apply)?

INDIVIDUAL THERAPY	FAMILY THERAPY	PSYCHIATRY/ MEDICATIONS	OTHER GROUP TREATMENT

4. How frequent were services?

ONCE A WEEK ONCE EVERY 2 WEEKS ONCE A MONTH OTHER:_____

Since _____ (date of pre-assessment), was your child hospitalized for psychiatric reasons? YES NO

Psychotropic medications

List all medications your child is <u>currently</u> taking for psychiatric purposes:

Medication Name	Type of Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____