MERIDELL ACHIEVEMENT CENTER
Psychosocial History

(Place name label here)

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **GENDER:** ☐M ☐F

1. FAMILY OF ORIGIN AND CURRENT CARETAKERS (check all that apply):

☐Biological parents ☐Mother ☐Father Name(s): _____
☐Adoptive parents ☐Mother ☐Father Name(s): _____
☐Step-parents ☐Mother ☐Father Name(s): _____
☐Maternal grandparents ☐Mother ☐Father Name(s): _____
☐Paternal grandparents ☐Mother ☐Father Name(s): _____
☐Deceased parents ☐Mother ☐Father Name(s): _____
☐Other _____ ☐_____ ☐_____ Name(s): _____
If not biological parent, how, and at what age did patient come into your care: _____

_____

☐Non-custodial ☐Mother ☐Father Name: _____
☐No rights ☐Mother ☐Father Name: _____
☐N/A ☐Custody of child with (legal guardian) Name: _____
☐N/A ☐Custody dispute in progress, current status: _____
☐N/A Describe custody arrangements (if applicable): _____

_____

_____

☐Will bring court documents at admission ☐N/A ☐Will fax court documents prior to admission
☐Divides time between households. Describe: _____

2. CURRENT HOUSEHOLD MEMBERS LIVING WITH PATIENT (parents, siblings, relatives and friends):

Relationship to Patient	Name	Age	Describe Relationship with Household Member

3. SIGNIFICANT FAMILY MEMBERS / RELATIVES / OTHERS NOT IN SAME HOUSEHOLD: ☐ **N/A**

Relationship to Patient	Name	Age	Describe Relationship with Other

4. FAMILY HISTORY OF MENTAL HEALTH ISSUES:

	☐Bio Maternal History Unknown Mother's Side Relationship to Patient	☐Bio Paternal History Unknown Father's Side Relationship to Patient
Psychiatric		
Neurological		
History of Suicide		
Substance Abuse		
Learning Disabilities		
Aggression		
Legal Issues		
Other		

PATIENT NAME: _____

(Place name label here)

5. DEVELOPMENTAL HISTORY:

Prenatal: ☐Normal or unremarkable ☐No information available

☐Problems with (eg, complications during pregnancy/delivery, substance use, etc.): _____

_____

Developmental Milestones:	☐Normal Limits	☐Delayed	☐No information available
Walking:	☐Early: _____	☐12-months	☐Later: _____
Talking in 3-word sentences:	☐Early: _____	☐24-months	☐Later: _____
Toilet Training:	☐Early: _____	☐36-months	☐Later: _____
Handedness: ☐Right	☐Left		

Birth to 1-year: ☐Normal or unremarkable ☐No information available

☐Problems with: _____

_____

2 to 5 years: ☐Normal or unremarkable ☐No information available

☐Problems with: _____

_____

When this age, was able to or if currently this age, is able to:

☐No	☐Yes	Hop or skip	☐No	☐Yes	Interact with others in play
☐No	☐Yes	Knows first and last name	☐No	☐Yes	Able to separate from parents briefly

6 to 12 years: ☐Normal or unremarkable ☐No information available

☐Problems with: _____

_____

At this age was able to or if currently this age is able to:

For patients 6-8 years old:			For patients 9-12 years old:		
☐No	☐Yes	Bathes, dresses, combs hair	☐No	☐Yes	Has a best friend
☐No	☐Yes	Assumes responsibility	☐No	☐Yes	Has a hobby
☐No	☐Yes	Participates in household chores	☐No	☐Yes	Reads newspaper/magazines
☐No	☐Yes	Able to verbalize their needs	☐No	☐Yes	Interested in current news events
☐No	☐Yes	Plays games with other kids	☐No	☐Yes	Involved in family discussions
☐No	☐Yes	Can cooperate in activities	☐No	☐Yes	Assumes responsibilities for self and belongings

13 to 18 years: ☐Normal or unremarkable ☐No information available

☐Problems with: _____

_____

If currently in this age group, is able to:			Patient is able to instigate and maintain:		
☐No	☐Yes	Demonstrate independent decision making	☐No	☐Yes	Involvement with peer groups
☐No	☐Yes	Demonstrate interest in future career goals	☐No	☐Yes	Involvement in team sports/social activities/ school activities

The patient currently functions: ☐At age level ☐Above age level ☐Below age level

Discipline used with patient? _____

_____

Significant / relevant issues from childhood impacting current illness (eg, recent, frequent moves, change in schools, abuse, trauma, medical issues, loss of parent, divorce, abandonment, etc):

_____

_____

_____

PATIENT NAME: _____

(Place name label here)

6. EDUCATION:

Current grade level: _____ History of repeating a grade: ☐No ☐Yes Which grade(s):_____
Current grades: _____ ☐Improving ☐Declining ☐Typically _____
Language spoke: ☐English ☐Spanish ☐Other, please specify:_____
Reading preference: ☐English ☐Spanish ☐Other, please specify:_____
Learns best by: ☐Listening ☐Reading ☐Demonstration ☐Participation ☐Eager to Learn
Learning barriers: ☐Reading & writing difficulties ☐Speech impediments ☐Impaired vision
☐Fatigue ☐Other, description of symptoms and age when began: _____

_____

☐Patient is currently enrolled in school. School name: _____
Address: _____

_____

☐Patient is currently home schooled. Reason: _____
☐Not enrolled or attending school due to: ☐Dropped out ☐Refuses to attend ☐Other_____
☐No ☐Yes School behavioral problems? Details (eg, age of onset, specific behaviors, school consequences): _____

_____

☐No ☐Yes Patient has a history of requiring 1:1 educational aide for behavioral management?
☐No ☐Yes Patient has a 504 plan for: ☐Medical _____ ☐Behavioral _____
☐Other _____
☐No ☐Yes Special Educational Services: What is their qualifying diagnosis? _____
Date of last IEP meeting: _____ Details (eg, accommodations, age when services began, services received): _____
***Please provide most recent copies of educational plans at the time of admission.**

☐No ☐Yes School Strengths. Describe: _____

_____

7. SOCIAL HISTORY:

Patient is able to create friendships.	☐Never	☐Rarely	☐Sometimes	☐Always
Patient is able to maintain friendships.	☐Never	☐Rarely	☐Sometimes	☐Always
Patient is able to relate to peers in a respectful manner.	☐Never	☐Rarely	☐Sometimes	☐Always
Patient is able to relate to adults in a respectful manner.	☐Never	☐Rarely	☐Sometimes	☐Always
Patient participates in leisure/recreation/hobby activities.	☐Never	☐Rarely	☐Sometimes	☐Always

8. AREAS OF SKILL DEFICITS OR CHRONIC PROBLEMS:

☐Withdrawn/Isolating
☐Low self-esteem
☐Self-defeating
☐Loss of interest in activities
☐Expresses strange thoughts
☐Overwhelmed
☐Cries easily
☐Worried / Anxious
☐Separation anxiety
☐Specific fears or phobias
☐Afraid to sleep alone
☐Panic attacks
☐Lots of physical complaints
☐Pulling out hair, eyelashes, brows
☐Refusal to eat
☐Binge eating
☐Self-induced vomiting
☐Hides food / Hoarding
☐Easily lead astray
☐Can't delay wants
☐Fails to learn from experience

☐Inability to set goals
☐Electronic misuse
☐Gaming obsessions
☐Memory lapses
☐Racing thoughts
☐Hyper-talkative
☐Repetitive behaviors
☐Obsessing
☐Bores Easily / Craves Stimulation
☐Grandiose sense of self-worth
☐Disrespectful
☐Argumentative
☐Cursing at authority
☐Over-reacts to events
☐Rages / Temper tantrums
☐Setting fires

DIFFICULTY WITH:

☐Handling transitions
☐Shifting from original idea or plan
☐Progressing logical sequence
☐Inflexible, inaccurate cognitive distortions

☐Persisting on challenging / tedious tasks
☐Attending to or interpreting social cues
☐Maintaining focus
☐Starting conversations, entering groups
☐Maintaining sense of time
☐Seeking attention in appropriate ways
☐Considering consequences of actions
☐Appreciating how own behavior affects others
☐Finding range of solutions to problem
☐Empathizing with others, seeing their perspective
☐Expressing self in words
☐Perceiving how s/he is coming across to others
☐Understanding what is being said
☐Sensory / motor difficulties
☐Managing emotional response to frustration
☐Irritability that interfere with problem-solving
☐Being a concrete / black-and-white thinker
☐Assessing situational reasons to alter plan
☐Deviating from routine / structure
☐Handling unpredictability, uncertainty
☐Other _____

PATIENT NAME: _____

(Place name label here)

9. ELOPEMENT: ☐**NO HISTORY OF RUNNING AWAY**

☐No ☐Yes Threatens to run away? ☐No ☐Yes Interventions have prevented elopement?

☐No ☐Yes Patient has run away from home? When did patient last run? _____

If yes, frequency: _____ Is it planned? _____

Where did patient go? _____

How long was patient gone? _____ How did patient get back home? _____

☐No ☐Yes Patient was in harm's way during elopement? Details: _____

_____

☐No ☐Yes Patient has run away while in a treatment setting? Details: _____

_____

10. HISTORY OF SUICIDAL IDEATIONS / ATTEMPTS: ☐**NO HISTORY OF SUICIDAL IDEATIONS**

☐No ☐Yes History of self-harming behaviors? Describe: ☐Head-banging ☐Scratching ☐Biting ☐Hitting ☐Pulling out or shaving hair, eyelashes or eyebrows ☐Cutting ☐Burning ☐Self-Piercing ☐Self-tattooing ☐Other: _____

Patient's mood during suicidal ideations? ☐Angry ☐Sad ☐Depressed ☐Manipulative ☐Other _____

☐No ☐Yes Patient has verbalized suicidal ideations? When: _____

☐No ☐Yes Patient has verbalized plan? Describe: _____

☐No ☐Yes Patient has made a suicidal gesture/attempt? Details: _____

_____

☐No ☐Yes Suicidal gesture could / would have resulted in patient's death without interventions?

Date	Age	Method	Injury	Treatment / Outcome

☐No ☐Yes Patient has access to a gun or other weapons? _____

☐No ☐Yes There are guns or other weapons in the home? Describe how they are secured: _____

_____

☐No ☐Yes There are other weapons in the home associated with hobbies or collections? Describe how they are secured: _____

☐No ☐Yes There are other potentially dangerous items in the home (eg, medications)? Describe how they are secured:

_____

If weapons and/or other potentially dangerous items in the home are not secured, how will this be managed in the future?

_____

☐No ☐Yes Patient has access to lethal means other than home environment? Describe: _____

_____

11. HISTORY OF VIOLENT / AGGRESSIVE / ANTISOCIAL BEHAVIORS:

☐No ☐Yes Patient has a history of violent or aggressive behaviors

☐No ☐Yes Aggressive behaviors have been directed towards: ☐Parents ☐Siblings ☐Peers ☐School

☐No ☐Yes Aggressive behaviors are escalating and/or are more frequent

☐No ☐Yes Patient plans aggressive acts

☐No ☐Yes Patient is very careful to protect self when aggressive

☐No ☐Yes Patient can control behavior when aggressive

☐No ☐Yes Patient hides or attempts to hide aggressive acts

☐No ☐Yes Patient steals from: ☐Family ☐Friends ☐School ☐Stores ☐Neighbors ☐Others_____

☐No ☐Yes Patient has history of delusions or command hallucinations prompting them to be aggressive

☐No ☐Yes Patient experiences rapid mood swings

☐No ☐Yes Patient experiences paranoid ideation

☐No ☐Yes Physical aggression appears to be without gain or purpose

☐No ☐Yes Patient aggression is unplanned, out of the blue

☐No ☐Yes Patient is completely out of control when aggressive

☐No ☐Yes Patient exposes self to physical harm when aggressive

☐No ☐Yes Patient destroys own property without apparent profit or gain

PATIENT NAME: _____

(Place name label here)

HISTORY OF VIOLENT / AGGRESSIVE / ANTISOCIAL BEHAVIORS (continued):

☐No ☐Yes Patient vandalizes or destroys others property or belongings?

☐No ☐Yes Patient has been physically aggressive with a weapon? Describe (eg, patient age, victim, weapon used, extent of injury to victim): _____

☐No ☐Yes Patient has been physically aggressive and/or cruel to animals? Describe: _____

_____

☐No ☐Yes Patient has expressed a plan to retaliate against someone? Who? _____

How? _____

What are the precipitating events that typically trigger the patient's aggressive behaviors? _____

_____

Types of physical aggression towards others:

☐Pushing	☐Punching	☐Head Butting	☐Stabbing	☐_____
☐Shoving	☐Biting	☐Pushing Down	☐Choking	☐_____
☐Hitting	☐Scratching	☐Kicking	☐Smothering	☐_____

12. LEGAL HISTORY: **☐NO LEGAL ISSUES**

☐No ☐Yes Patient has been arrested? Describe (eg, patient age, offense, outcome): _____

_____

☐No ☐Yes Patient is currently on probation/parole? Name and county of Probation Officer: _____

_____

☐No ☐Yes Patient has charges pending? Describe (eg, patient age, offense, court date): _____

_____

☐No ☐Yes Current illness has affected legal history? Describe: _____

_____

13. PATIENT HISTORY OF ALCOHOL AND DRUG USE: **☐NO HISTORY OF USE**

☐Suspected, unconfirmed ☐Experimentation ☐Becoming problematic ☐Big problem

Generally uses ☐Alone ☐With others _____

How does the patient procure or pay for drugs? _____

Check all used:

☐Caffeine	☐Stimulants	☐Marijuana	☐Opiates
☐Diet Aids / Diuretics	☐Steroids	☐Inhalants	☐Ecstasy / GHB
☐Laxatives	☐Pain Medications	☐Methadone	☐PCP
☐Over the counter meds	☐Sedatives	☐Crystal Meth	☐Prescriptions
☐Tobacco	☐Tranquilizers	☐Hallucinogens	
☐Alcohol	☐Barbiturates	☐Cocaine / Crack	

Substance Checked or Other	Type	Age of First Use	Date of Last Use	Age Regular Use Began	Current Use Pattern	Highest Quantity in 24 hours

☐No ☐Yes Diagnosis of Chemical Dependency / Abuse? Drug of Choice?_____

☐No ☐Yes Treatment previously received for drug use? ☐Therapy / Counseling ☐Hospitalization / Rehab

☐No ☐Yes Has used again since treatment? How soon after treatment? _____

PATIENT NAME: _____

(Place name label here)

14. SEXUAL:

Has identified sexual preference as: ☐Heterosexual ☐Bi-Sexual ☐Gay / Lesbian ☐Other _____

☐No ☐Yes Identifies as Transgender? ☐Transgender Male / Trans man / FTM
☐Transgender Female / Trans woman MTF

What is the patient's legal name? _____

(Optional) What is patient's preferred name or nickname? _____

(Optional) What pronouns does patient use to refer to self (eg, he/him, she/her)? _____

What is the gender designation on patient's medical insurance records? ☐Male ☐Female

☐No ☐Yes Patient is sexually active?

☐No ☐Yes Patient practices safe sex? ☐ N/A

☐Sexual behaviors were with / toward:

☐Same age peers ☐Younger ☐Older ☐Parents ☐Siblings
☐Opposite sex ☐Same sex ☐Both male and female ☐Animals

Sexual Behaviors (Please Check All That Apply)	Age of Patient When First Occurred	Frequency	How Long Has Behavior Been Occurring?
☐Sexual preoccupation			
☐Sexually explicit talk			
☐Sexually explicit writings / drawings			
☐Has used electronic media for "sexting" / sex chat rooms / viewing pornography / posting inappropriate pictures of self			
☐Engaged in voyeurism / peeping			
☐Exposed self to others			
☐Sexually promiscuous			
☐Masturbation in presence of others			
☐Acted out sexually in a treatment setting			
☐Touched others sexually without their permission			
☐Sexually aggressive / predatorial			
☐Gender identify issues			

☐No ☐Yes Has experienced a sexual assault or been victimized? Age / perpetrator / circumstances: _____

_____

☐No ☐Yes Was this suspected abuse of patient reported to a State protective service?

Please provide additional information on checked behaviors above: _____

_____

☐No ☐Yes Received serious consequences due to sexual behaviors (eg, school expulsion/suspension, legal/social services involvement)? What age was patient? _____ What were charges? _____

_____

☐No ☐Yes Patient accepts responsibility for their sexual behavior?

☐No ☐Rarely ☐Mostly ☐Yes Patient is able to manage sex urges?

☐No ☐Yes Has patient received treatment for sexual behaviors? Describe: _____

_____

☐No ☐Yes Does patient have pet allergies?

☐No ☐Yes Does patient have history of aggression to animals?

☐No ☐Yes Does patient have anxiety or history of being attacked by an animal?

For any responses "yes" to above questions, please specify below including type of animal and description of incident(s): _____

_____

_____

PATIENT NAME: _____

(Place name label here)

15. BEREAVEMENT:

Relationship to Patient	Name of Person / Other	Type of Loss (Death, Divorce, Etc.)	Age of Patient at Time of Loss	How Has This Loss Affected the Patient?

☐No ☐Yes There are cultural / religious / ethnic factors affecting patient's bereavement process? Explain: _____

☐No ☐Yes Patient's current illness is affected by the loss? Explain: _____

☐No ☐Yes Patient is involved in community bereavement resources? Describe: _____

16. CULTURAL INFLUENCES / RELIGIOUS BACKGROUND / CURRENT ACTIVITY:

☐No ☐Yes Patient has expressed a belief system or spiritualness? _____
☐No ☐Yes Patient has a religious affiliation: _____
☐No ☐Yes Patient attends religious services? Name of church / temple? _____
☐No ☐Yes Patient's affiliation with a place of worship is part of his/her support system? Explain: _____

☐No ☐Yes Patient's current illness has affected his/her spiritual life. Explain: _____

Patient and family's cultural / ethnic background? _____

☐No ☐Yes The family has specific cultural/ethnic/religions factors that should be considered during treatment? Explain: _____

17. DIAGNOSTIC HISTORY: The patient has previously been diagnosed with:

☐Adjustment Disorder	☐Disruptive Mood Dysregulation	☐Mood Disorder	☐Post-Traumatic Stress Disorder
☐Anxiety Disorder	☐Eating Disorder	☐Neurodevelopmental Disorder	☐Psychosis
☐ADD / ADHD	☐Fetal Alcohol Syndrome	☐Obsessive Compulsive Disorder	☐Reactive Attachment Disorder
☐Autism Spectrum Disorder	☐Impulse Control Disorder	☐Oppositional Defiant Disorder	☐Schizoaffective Disorder
☐Bipolar Disorder	☐Intermittent Explosive Disorder	☐Paranoid Disorder	☐Substance Abuse
☐Cerebral Dysrhythmia	☐Learning Disorder	☐Personality Disorder	☐Other _____
☐Conduct Disorder	☐Major Depressive Disorder	☐Pervasive Development Disorder	☐Other _____

18. HISTORY OF PREVIOUS TREATMENT: ☐Last treatment more than 2 years ago

☐No ☐Yes Inpatient hospitalization (Acute), Residential Treatment Center (RTC), Intensive Outpatient (IOP), Partial Hospitalization (PHP), over the last few years.

Name of Facility (Most Recent First)	Date(s) of Treatment	Sending Record to Meridell		Treatment Results		
		Yes	No	Positive	Negative	None
		Yes	No	Positive	Negative	None
		Yes	No	Positive	Negative	None
		Yes	No	Positive	Negative	None

☐No ☐Yes Patient placed in a private bedroom due to patient behaviors (eg, aggression, sexual acting out)? Specify reason: _____
☐No ☐Yes Did patient require special staffing (eg, 1:1)? Specify: _____

☐No ☐Yes Did patient require seclusions, physical holds or injections due to behavioral issues? Describe: _____

PATIENT NAME: _____

(Place name label here)

19. OUTPATIENT PROVIDERS:

Outpatient Therapy, Therapist, Psychiatrist, etc, in the last couple of years?

Providers	Phone & Fax #	Treatment Dates	Release of Information Signed for MAC	Treatment Results & Email Address	Will Resume Treatment With Patient After Discharge
			Yes No	Positive Negative None	Yes No
			Yes No	Positive Negative None	Yes No
			Yes No	Positive Negative None	Yes No

☐No ☐Yes We plan to continue with these providers after discharge and are providing **all** of their contact information to you, to establish communication regarding the care aftercare of my child.

☐No ☐Yes I would like assistance identifying new outpatient mental health providers for our family.

20. COMMUNITY RESOURCES CURRENTLY BEING USED BY PATIENT / FAMILY:

Resource	Used To / For

21. RESIDENCE / CONTACT INFO:

Patient's Primary Residence With: _____

Address: _____

Home #: _____
Cell #: _____
Other #: _____

Patient's Secondary Residence With: _____

Address: _____

Home #: _____
Cell #: _____
Other #: _____

22. PRECIPITATING EVENTS NECESSITATING TREATMENT INTERVENTIONS AT THIS TIME:

_____ _____ _____ _____

Completed By | Relationship to Patient | Email Address | Date