Collaborative Change

Collaborative Change Initial Checklist – *CHILD*

Name of person completing form: _____ Date: _____

PRESENTING ISSUE

1. What is the primary reason for which you are seeking help? (please check)

Physical Problems
Attention Issues
Grieving
Abuse or Trauma
Anxiety or Worry
LGBTQ+
Other (Explain on the Right)

2. How long have you have this issue(s) been present?

3. Have you received treatment for this issue or any other issue in the past? ☐ Yes ☐ No

FAMILY HISTORY

1. Have you had any family history of alcohol abuse within your family (Please circle all that apply):

Fraternal Grandmother Abused Alcohol
Fraternal Grandfather Abused Alcohol
Fraternal Aunt Abused Alcohol
Fraternal Uncle Abused Alcohol
Other (Explain on the Right)
None

2. Have you had any family history of drug abuse within your family (Please circle all that apply):

Fraternal Grandmother Abused Drugs
Fraternal Grandfather Abused Drugs
Fraternal Aunt Abused Drugs
Fraternal Uncle Abused Drugs
Other (Explain on the Right)
None

2. Was there any type of abuse in your family/home? ☐ Yes ☐ No

If yes, please check which: ☐ Physical Abuse ☐ Sexual Abuse ☐ Emotional Abuse ☐ Domestic Violence

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MEDICAL HISTORY

1. Please check the appropriate box if you have experienced any of these issues:

- ☐ Eye disease, injury, poor vision
- ☐ Ear disease, injury, poor hearing
- ☐ Nose, sinus, mouth, throat problems
- ☐ Head injury
- ☐ Convulsions or seizures
- ☐ Memory problems
- ☐ Extreme tiredness or weakness
- ☐ Thyroid disease or goiter
- ☐ Skin disease
- ☐ Heart disease
- ☐ Back, arm, leg or joint problems
- ☐ Blood disease
- ☐ Stomach problems
- ☐ Premenstrual Syndrome (PMS)
- ☐ Eating disorder
- ☐ Liver, gallbladder disease
- ☐ Chest pain or angina pectoris
- ☐ Cancer
- ☐ Bowel problems
- ☐ Hemorrhoids, rectal bleeding
- ☐ Loss of consciousness
- ☐ Frequent or severe headaches
- ☐ Sleep disturbances
- ☐ Neck stiffness, pain, swelling
- ☐ Marked weight changes
- ☐ Circulatory problems
- ☐ Allergies or asthma
- ☐ Diabetes
- ☐ Encephalitis
- ☐ Meningitis
- ☐ Pregnancy not carried to term/stillbirths
- ☐ High blood pressure
- ☐ Other _____

2. Please explain anything checked above:

3. Please circle which best describes your sleeping patterns:

Sleep 6 or More Hours Without Issue
Sleep Less Than 6 Hours Daily
Trouble Falling Asleep
Trouble Staying Asleep
Don't Feel Rested After Sleep
Other (Explain on the Right)