Personal History—Children and Adolescents (<18)

Client's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____ Grade in school: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ Ext: _____

If you need any more space for any of the following questions please use the back of the sheet.

Primary reason(s) for seeking services:

___ Anger management ____ Anxiety ____ Coping ____ Depression

___ Eating disorder ____ Fear/phobias ____ Mental confusion ____ Sexual concerns

___ Sleeping problems ____ Addictive behaviors ____ Alcohol/drugs ____ Hyperactivity

___ Other mental health concerns (specify): _____

_____

Family History

Parents

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

If Yes, who has legal custody? _____

Were the child's parents ever married? ____ Yes ____ No

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? _____ Yes ____ No

If Yes, describe: _____

Client's Mother

Name: _____ Age: _____ Occupation: _____ ___ FT __ PT

Where employed: _____ Work phone: _____

Mother's education: _____

Is the child currently living with mother? ___ Yes ____ No

___ Natural parent ____ Step-parent ____Adoptive parent ____Foster home ____ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the mother?

___ Yes __ No If Yes, please explain: _____

_____

How is the child disciplined by the mother? _____

For what reasons is the child disciplined by the mother? _____

Client's Father

Name: _____ Age: _____ Occupation: _____ ___ FT __ PT

Where employed: _____ Work phone: _____

Father's education: _____

Is the child currently living with father? _____ Yes ____ No

___ Natural parent ____ Step-parent ____Adoptive parent ___Foster home ____ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the father?

___ Yes __ No If Yes, please explain: _____

_____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
_____	____	____ F ____ M	____ home ____ away	____ poor ____ average ____ good
_____	____	____ F ____ M	____ home ____ away	____ poor ____ average ____ good
_____	____	____ F ____ M	____ home ____ away	____ poor ____ average ____ good
_____	____	____ F ____ M	____ home ____ away	____ poor ____ average ____ good
Others living in the household			Relationship (e.g., cousin, foster child)	
_____	____	____ F ____ M	_____	____ poor ____ average ____ good
_____	____	____ F ____ M	_____	____ poor ____ average ____ good
_____	____	____ F ____ M	_____	____ poor ____ average ____ good
_____	____	____ F ____ M	_____	____ poor ____ average ____ good

Comments: _____

_____

_____

Family Health History

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

___ Allergies
___ Anemia
___ Asthma
___ Bleeding tendency
___ Blindness
___ Cancer
___ Cerebral Palsy
___ Cleft lips
___ Cleft palate
____ Deafness
____ Diabetes
____ Glandular problems
____ Heart diseases
____ High blood pressure
____ Kidney disease
____ Mental illness
____ Migraines
____ Multiple sclerosis
____ Muscular Dystrophy
____ Nervousness
____ Perceptual motor disorder
____ Mental Retardation
____ Seizures
____ Spinal Bifida
____ Suicide
____ Other (specify): _____
_____

Comments re: Family Health: _____

_____

Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurances of miscarriages or stillborns? _____ Yes ____ No

If Yes, describe: _____

Was the pregnancy with child planned? _____ Yes ____ No Length of pregnancy: _____

Mother's age at child's birth: _____ Father's age at child's birth: _____

Child number ___ of ____ total children.

How many pounds did the mother gain during the pregnancy? _____

While pregnant did the mother smoke? ___ Yes __ No If Yes, what amount: _____

Did the mother use drugs of alcohol? ___ Yes __ No If Yes, type/amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication)

_____ Yes ____ No

If Yes, describe: _____

Length of labor: _____ Induced: ___ Yes ____ No Caesarean? __ Yes ____ No

Baby's birth weight: _____ Baby's birth length: _____

Describe any physical or emotional complications with the delivery: _____

_____

Describe any complications for the mother or the baby after the birth: _____

_____

Length of hospitalization: Mother: _____ Baby: _____

Infancy/Toddlerhood Check all which apply:

___ Breast fed	____ Milk allergies	____ Vomiting	____ Diarrhea
___ Bottle fed	____ Rashes	____ Colic	____ Constipation
___ Not cuddly	____ Cried often	____ Rarely cried	____ Overactive
___ Resisted solid food	____ Trouble sleeping	____ Irritable when awakened	____ Lethargic

Developmental History Please note the age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____

Took 1st steps: _____ Tied shoelaces: _____

Spoke words: _____ Rode two-wheeled bike: _____

Spoke sentences: _____ Toilet trained: _____

Weaned: _____ Dry during day: _____

Fed self: _____ Dry during night: _____

Compared with others in the family, child's development was: _____ slow ____ average ____ fast

Age for following developments (fill in where applicable)

Began puberty: _____ Menstruation: _____

Voice change: _____ Convulsions: _____

Breast development: _____ Injuries or hospitalization: _____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

_____

_____

Education

Current school: _____ School phone number: _____

Type of school: ____ Public ____ Private __ Home schooled _____ Other (specify): _____

Grade: _____ Teacher: _____ School Counselor: _____

In special education? ____ Yes ___ No If Yes, describe: _____

In gifted program? ___ Yes _____ No If Yes, describe: _____

Has child ever been held back in school? _____ Yes _____ No If Yes, describe: _____

Which subjects does the child enjoy in school? _____

Which subjects does the child dislike in school? _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? _____ Yes ____ No

If Yes, describe: _____

Has the child been tested psychologically? ____ Yes __ No

If Yes, describe: _____

Check the descriptions which specifically relate to your child.

Feelings about School Work:

___ Anxious ____ Passive ____ Enthusiastic ____ Fearful

___ Eager ____ No expression ____ Bored ____ Rebellious

___ Other (describe): _____

Approach to School Work:

___ Organized ____ Industrious _____ Responsible _____ Interested

___ Self-directed ____ No initiative _____ Refuses _____ Does only what is expected

___ Sloppy ____ Disorganized _____ Cooperative _____ Doesn't complete assignments

___ Other (describe): _____

Performance in School (Parent's Opinion):

___ Satisfactory ____ Underachiever ____ Overachiever

___ Other (describe): _____

Child's Peer Relationships:

___ Spontaneous _____ Follower ____ Leader ____ Difficulty making friends

___ Makes friends easily _____ Long-time friends ____ Shares easily

___ Other (describe): _____

Who handles responsibility for your child in the following areas?

School: _____ Mother _____ Father _____ Shared __ Other (specify): _____

Health: _____ Mother _____ Father _____ Shared __ Other (specify): _____

Problem behavior: _____ Mother _____ Father _____ Shared __ Other (specify): _____

If the child is involved in a vocational program or works a job, please fill in the following:

What is the child's attitude toward work? ____ Poor ___ Average _____ Good ____ Excellent

Current employer: _____ Position: _____ Hours per week: _____

How have the child's grades in school been affected since working? _____ Lower _____ Same ____ Higher

How many previous jobs or placements has the child had? _____

Usual length of employment: _____ Usual reason for leaving: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?

Medical/Physical Health

___ Abortion	____ Hayfever	____ Pneumonia
___ Asthma	____ Heart trouble	____ Polio
___ Blackouts	____ Hepatitis	____ Pregnancy
___ Bronchitis	____ Hives	____ Rheumatic Fever
___ Cerebral Palsy	____ Influenza	____ Scarlet Fever
___ Chicken Pox	____ Lead poisoning	____ Seizures
___ Congenital problems	____ Measles	____ Severe colds
___ Croup	____ Meningitis	____ Severe head injury
___ Diabetes	____ Miscarriage	____ Sexually transmitted disease
___ Diphtheria	____ Multiple sclerosis	____ Thyroid disorders
___ Dizziness	____ Mumps	____ Vision problems
___ Ear aches	____ Muscular Dystrophy	____ Wearing glasses
___ Ear infections	____ Nose bleeds	____ Whooping cough
___ Eczema	____ Other skin rashes	____ Other
___ Encephalitis	____ Paralysis	_____
___ Fevers	____ Pleurisy	

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____ / week	_____	____ No ___ Low ____ Med ____ High
Lunch	____ / week	_____	____ No ___ Low ____ Med ____ High
Dinner	____ / week	_____	____ No ___ Low ____ Med ____ High
Snacks	____ / week	_____	____ No ___ Low ____ Med ____ High

Comments: _____

Most recent examinations

Type of examination	Date of most recent visit	Results
Physical examination		
Dental examination		
Vision examination		
Hearing examination		

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Immunization record (check immunizations the child/adolescent has received):

	DPT	Polio
2 months	____	____
4 months	____	____
6 months	____	____
18 months	____	____
4–5 years	____	____

15 months _____ MMR (Measles, Mumps, Rubella)
24 months ____ HBPV (Hib)
Prior to school ____ HepB

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? ____ Yes ___ No

If Yes, describe: _____

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

	Yes	No	When	Where	Reaction or overall experience
Counseling/Psychiatric treatment	____	____			
Suicidal thoughts/attempts	____	____			
Drug/alcohol treatment	____	____			
Hospitalizations	____	____			

Behavioral/Emotional

Please check any of the following that are typical for your child:

___ Affectionate
___ Aggressive
___ Alcohol problems
___ Angry
___ Anxiety
___ Attachment to dolls
___ Avoids adults
___ Bedwetting
___ Blinking, jerking
___ Bizarre behavior
___ Bullies, threatens
___ Careless, reckless
___ Chest pains
___ Clumsy
___ Confident
___ Cooperative
___ Cyber addiction
___ Defiant
___ Depression
___ Destructive
___ Difficulty speaking
___ Dizziness
___ Drugs dependence
___ Eating disorder
___ Enthusiastic
___ Excessive masturbation
___ Expects failure
___ Fatigue
___ Fearful
___ Frequent injuries
____ Frustrated easily
____ Gambling
____ Generous
____ Hallucinations
____ Head banging
____ Heart problems
____ Hopelessness
____ Hurts animals
____ Imaginary friends
____ Impulsive
____ Irritable
____ Lazy
____ Learning problems
____ Lies frequently
____ Listens to reason
____ Loner
____ Low self-esteem
____ Messy
____ Moody
____ Nightmares
____ Obedient
____ Often sick
____ Oppositional
____ Over active
____ Overweight
____ Panic attacks
____ Phobias
____ Poor appetite
____ Psychiatric problems
____ Quarrels
____ Sad
____ Selfish
____ Separation anxiety
____ Sets fires
____ Sexual addiction
____ Sexual acting out
____ Shares
____ Sick often
____ Short attention span
____ Shy, timid
____ Sleeping problems
____ Slow moving
____ Soiling
____ Speech problems
____ Steals
____ Stomach aches
____ Suicidal threats
____ Suicidal attempts
____ Talks back
____ Teeth grinding
____ Thumb sucking
____ Tics or twitching
____ Unsafe behaviors
____ Unusual thinking
____ Weight loss
____ Withdrawn
____ Worries excessively
____ Other:
_____
_____

Please describe any of the above (or other) concerns: _____

_____

How are problem behaviors generally handled? _____

_____

What are the family's favorite activities? _____

_____

What does the child/adolescent do with unstructured time? _____

_____

Has the child/adolescent experienced death? (friends, family pets, other) _____ Yes ____ No
At what age? _____ If Yes, describe the child's/adolescent's reaction: _____

_____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)
___ Yes ___ No If Yes, describe: _____

_____

Any additional information that you believe would assist us in understanding your child/adolescent?

_____

_____

_____

Any additional information that would assist us in understanding current concerns or problems?

_____

_____

_____

What are your goals for the child's therapy? _____

_____

What family involvement would you like to see in the therapy? _____

_____

Do you believe the child is suicidal at this time? _____ Yes _____ No
If Yes, explain: _____

_____

I recognize that the above information will be used in and form part of the basis for both my (or my child's) treatment and diagnosis.

_____ _____

Client / Parent or Guardian Signature Today's date

For Staff Use

Therapist's signature/credentials: _____ Date: _____/____/_____

Therapist's comments: _____

_____

_____ Physical exam: ___ Advised? ____ Not required