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? ____

Where 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 ___ Stepparent ___ 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 ___ Stepparent ___ Adoptive parent ___ Foster home ___ Other (specify): _______

If 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

Name 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	____ Deafness	____ Muscular dystrophy
____ Anemia	____ Diabetes	____ Nervousness
____ Asthma	____ Glandular problems	____ Perceptual motor disorder
____ Bleeding tendency	____ Heart diseases	____ Mental retardation
____ Blindness	____ High blood pressure	____ Seizures
____ Cancer	____ Kidney disease	____ Spina bifida

____ Cerebral palsy ____ Mental illness ____ Suicide
____ Cleft lips ____ Migraines ____ Other (specify): __________
____ Cleft palate ____ Multiple sclerosis ____________________
____ Comments re: Family Health:______________________________

____

CHILDHOOD/ADOLESCENT HISTORY

PREGNANCY/BIRTH

Has the child's mother had any occurrences of miscarriages or stillbirths? ___ Yes ___ No

If Yes, describe: ______________________________

Was the pregnancy with child planned? ___ Yes ___ NoLength 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-wheel 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 that specifically relate to your child.

FEELINGS ABOUT SCHOOLWORK:

___ Anxious ___ Passive ___ Enthusiastic ___ Fearful
___ Eager ___ No expression ___ Bored ___ Rebellious

___ Other (describe): ____

APPROACH TO SCHOOLWORK:

___ 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 ___ Longtime 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
___ Asthma
___ Blackouts
___ Bronchitis
___ Cerebral palsy
___ Chicken pox
___ Congenital problems
___ Croup
___ Diabetes
___ Diphtheria
___ Dizziness
___ Earaches
___ Ear infections
___ Eczema
___ Encephalitis
___ Fevers
___ Hay fever
___ Heart trouble
___ Hepatitis
___ Hives
___ Influenza
___ Lead poisoning
___ Measles
___ Meningitis
___ Miscarriage
___ Multiple sclerosis
___ Mumps
___ Muscular dystrophy
___ Nosebleeds
___ Other skin rashes
___ Paralysis
___ Pleurisy
___ Pneumonia
___ Polio
___ Pregnancy
___ Rheumatic fever
___ Scarlet fever
___ Seizures
___ Severe colds
___ Severe head injury
___ Sexually transmitted disease
___ Thyroid disorders
___ Vision problems
___ Wearing glasses
___ Whooping cough
___ Other
____

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
Counselling/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
___ Drug 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
___ Overactive
___ 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
___ Stomachaches
___ 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: ____________________

FOR STAFF USE

Therapist's comments: ____________________

Therapist's signature/credentials: ____________________ Date: ___/___/______

Supervisor's comments: ____________________

____ Physical exam: ___ Required ___ Not required

Supervisor's signature / credentials: ______________________________ Date: ___/___/_____
(Certifies case assignment, level of care and need for exam)