Personal History—Children and Adolescents (< 18)

Client's name: _____ Date: _____

Gender: ____F ____ M Date of birth: _____ Age: _____ Grade in school: _____

Child's Social Security Number:_____

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

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

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

Phone (cell):_____

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 ___ 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: _____ Spoke words: _____
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

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

_____

_____

EDUCATION

Current school: _____ School phone number: _____

Grade: _____ In special education? ___ Yes ___No In gifted program? ___ Yes ___ No

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: _____ 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: _____

SLEEP

Total # Hrs slept per night:_____ Total # Awakening per night:_____

Time Go to Bed:_____ Time Fall Asleep:_____ Time Wake Up:_____

Do You Feel Rested When you Wake Up? Y N

Do you experience any of the following (check all that apply):

___ Snore ___ Move while you sleep ___ Sleepwalk
___ Night Terrors ___ Nightmares ___Talk in your sleep
___ Stop Breathing in sleep ___ Trouble falling asleep ___ Trouble staying asleep
___ Tired during the day ___Fall asleep in daytime ___Watch tv or read in bed
___Sleep with lights on ___Share a room/bed
___Need someone with you to fall asleep ___Other:_____

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
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Is child's vaccinations up to date? _____YES _____No

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
___ 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:_____

_____

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?_____