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Personal History – Children & Adolescents (<18 years)

Patient's name: ____ Date: _________________

Gender: ___ F ___ M Date of Birth: ____/_____/_______ Age: _____

Grade in School: ____________ School: ___________________________________

Home Address: ______________________________________ City: ____________________

State: _______ Zip Code: ___________

Home Phone: (____) _______ - __________ Work Phone: (____) ______ - _________ Ext: _________

Cell Phone: (____) _______ - ___________

Form Completed By: ____ Relation to Patient: __________________

Primary Reason(s) for Seeking Services:

___ Anger Management ___ Anxiety ___ Coping ___ Depression

___ Behavior Concerns ___ Fear/Phobias ___ Adjustment to Parental Divorce

___ Sleeping Problems ___ Attention Problems ___ Hyperactivity

___ Other Mental Health Concerns (Specify): ____

____

____

Family Social History

Parents

With whom does the child live at this time? ____

Are parents 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 by beneficial in counseling? ___ Yes ___ No

If yes, describe: ____

Patient's Mother

Name: ____ Age: _____ Occupation: __________________

Where employed? ____________________________________ Work Phone: (____) ______ - ______ Ext: _____

Mother's Highest Level of Education: _____________________________________

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

___ Natural Parent ___ Step-parent ___ Adoptive Parent ___ Foster Home ___ Other

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? ____

____

Patient's Father

Name: ____ Age: _____ Occupation: __________________

Where employed? ____________________________________ Work Phone: (____) ______ - ______ Ext: _____

Father's Highest Level of Education: _____________________________________

Is the child currently living with the father? ___ Yes ___ No

___ Natural Parent ___ Step-parent ___ Adoptive Parent ___ Foster Home ___ Other

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? ____

____

Patient's Siblings and Others Who Live in the Household

Name of Sibling	Age	Gender	Lives	Quality of Relationship with Patient
________________	___	___ M ___ F	___ Home ___ Away	___ Poor ____ Average ___ Good
________________	___	___ M ___ F	___ Home ___ Away	___ Poor ____ Average ___ Good
________________	___	___ M ___ F	___ Home ___ Away	___ Poor ____ Average ___ Good
________________	___	___ M ___ F	___ Home ___ Away	___ Poor ____ Average ___ Good
Others Living in the Household			Relationship (e.g., cousin, foster child)	
________________	___	___ M ___ F	__________________	___ Poor ____ Average ___ Good
________________	___	___ M ___ F	__________________	___ Poor ____ Average ___ Good
________________	___	___ M ___ F	__________________	___ Poor ____ Average ___ Good
________________	___	___ M ___ F	__________________	___ Poor ____ Average ___ Good

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Family History

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

___ Allergies	___ Depression	___ Migraines
___ Anemia	___ Diabetes	___ Muscular Dystrophy
___ Anxiety	___ Glandular Problems	___ Nervousness
___ Asthma	___ Heart Disease	___ Perceptual Motor Disorder
___ Autism	___ High Blood Pressure	___ Problems in School
___ Blindness	___ Kidney Disease	___ Seizures
___ Cancer	___ Learning Difficulties	___ Substance Use
___ Cerebral Palsy	___ Mental Illness	___ Suicide
___ Deafness	___ Mental Retardation	___ Other (Specify): ________________________

Additional Comments Regarding Family Health: ____

____

Childhood/Adolescent History

Pregnancy/Birth

Length of Pregnancy: ________________________

Child number _____ of _____ total children.

While pregnant did the mother smoke? ___ Yes ___ No If yes, what amount? ___________

Did the mother use drugs or 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, please describe? ____

Length of Labor: __________________ Induced? ___ Yes ___ No C-Section? ___ Yes ___ No

Any complications during labor? ___ Yes ___ No If yes, please describe? ________________________________

____

____

Baby's Birth Weight: _____ lbs ______ oz Baby's Length: _____ inches

Length of hospitalization following delivery: Mother: __________________ Baby: ____________________

Infancy/Toddler Years Check all which apply:

___ Breast fed ___ Milk allergies ___ Vomitting ___ Diarrhea

___ Bottle fed ___ Rashes ___ Colic ___ Constipation

___ Not cuddly ___ Cried often ___ Rarely cried ___ Overactive

___ Resisted solid foods ___ Trouble sleeping ___ Irritable when awakened ___ Lethargic

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

Sat alone __________________________ Dressed self __________________________

Took first steps _____________________ Spoke words _________________________

Rode two-wheeled bike ______________ Spoke sentences ______________________

Toilet trained _______________________ Fed self _____________________________

Dry during day ______________________ Dry during night _______________________

Compared to 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: (____) _____ - ________

Type of School: ____ Public ___ Private ___ Home Schooled ___ Other (Specify): _____________________________

Grade in School: _________ Primary Teacher's Name: _______________________________

School Counselor's Name: ____

Is the child in special education? ___ Yes ___ No If yes, please describe services received: ___________________

____

Is the child in gifted program? ___ Yes ___ No If yes, please describe program: __________________________

____

Current concerns regarding child's current performance in school (i.e., learning/behavior): ______________________

____

____

____

If the child is experiencing problems in school, when did the problems begin? _________________________________

____

____

What subject areas does the child enjoy in school? ____

Which subject areas 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, please describe: _______________

____

Has the child undergone psychological/psychoeducational testing? ___ Yes ___ No If yes, please 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/Careless ___ Disorganized ___ Cooperative ___ Doesn't complete tasks

___ Other (describe): ____

Performance in School (Parent's Opinion):

___ Satisfactory ___ Underachiever ___ Overachiever

___ Other (describe): ____

Child's Peer Relationships

Are there any concerns regarding your child's peer relationships? ___ Yes ___ No

If yes, please describe: ____

____

____

____

Check the descriptions which specifically relate to your child.

___ Spontaneous ___ Follower ___ Leader ___ Difficulty making friends

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

___ Other (describe): ____

Leisure/Recreational

Describe special areas of interest or hobbies your child engages in (e.g., art, books, physical fitness, sports, outdoor activities, church activities, exercising, diet/health, school activities, boy/girl scouts, etc.).

Activity	How often now?	How often in the past?
______________________	________________________	__________________________
______________________	________________________	__________________________
______________________	________________________	__________________________
______________________	________________________	__________________________

Medical/Physical Health

List any current health concerns: ____

____

List any recent health or physical changes: ____

____

Please check any illness your child has had and age at onset:

___ Asthma (age: _____)

___ Blackouts (age: ____)

___ Bronchitis (age: ____)

___ Hives (age: ____)

___ Cancer (age: ____)

___ Chicken Pox (age: ____)

___ Diabetes (age: ____)

___ Ear Infections (age: ____)

___ Hayfever (age: ____)

___ Heart trouble (age: ____)

___ Lead poisoning (age: ____)

___ Measles (age: ____)

___ Pneumonia (age: ____)

___ Seizures (age: ____)

___ Severe head injury (age: ____)

___ Nose bleeds (age: ____)

___ Thyroid problems (age: ____)

___ Vision problems (age: ____)

___ Other (please explain): ____

____

Substance Use History

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

If yes, please describe: ____

____

Counseling Treatment History

Is your child *currently* receiving counseling or psychiatric treatment? ___ Yes ___ No

If yes, please answer the following questions:

Current Provider: ______________________________ Phone Number: (____) ____ - ______

Date treatment began: ____ / ____ / _____ Frequency of treatment: ____________________

Focus of treatment/referral concerns: ____

____

Response to treatment: ____

____

Any medications prescribed? ___ Yes ___ No

If yes, type and dosage information: ____

Prior counseling or psychiatric treatment:

Provider: _________________________________

Date treatment began: ____ / ____ / ______ Length of treatment: _________________________

Focus of treatment/referral concerns: ____

____

Response to treatment: ____

____

Any medications prescribed? ___ Yes ___ No

If yes, type and dosage information: ____

Has your child ever been hospitalized due to psychiatric/mental health concerns? ___ Yes ___ No

If yes, please explain when and why your child was hospitalized: ______________________________

____

____

____

Behavioral/Emotional

Please describe your child's general mood (i.e., happy, sad, mood fluctuates frequently, etc.):

____

____

____

Are you concerned about your child's emotional functioning? ___ Yes ___ No

If yes, please explain: ____

____

____

Please describe your child's behavior at home, in general (i.e., compliant, disobedient, etc.):

____

____

____

Are you concerned about your child's behavior at home? ___ Yes ___ No

If yes, please explain: ____

____

____

What are the family's favorite activities? ____

____

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

____

Has the child/adolescent experienced death (i.e., friends, family members, pets, other)? ___ Yes ___ No

If yes, 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 (i.e., family move, natural disaster, etc.)?

___ Yes ___ No If yes, describe the child's/adolescent's reaction: ___________________________

____

Please describe your relationship with your child (i.e., activities you enjoy together, whether you feel your child can talk to you about issues/problems):

____

____

____

Any additional information that you believe would be helpful in understanding your child/adolescent?

____

____

____

____