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Personal History—Children and Adolescents

Client's name: _____ Date: _____
Gender: ___ F ___ M Date of birth: _____ Age: _____ Grade in school: _____
School: _____
Phone: _____
Form completed by: _____

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 History

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

Parent 1:

Name: _____ Age: _____ Occupation: _____
Education: _____
Is the child currently living with this parent? ___ Yes _____ No
____ Natural parent ___ Step-parent ____ Adoptive parent ____ Foster home ___ Other
Is there anything notable, unusual or stressful about the child's relationship with this parent?
___ Yes ____ No If Yes, please explain: _____

Parent 2:

Name: _____ Age: _____ Occupation: _____
Where employed: _____ Work phone: ___
Education: _____
Is the child currently living with this parent? ___ 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: _____

<u>If the child has a stepparent, please include his/her info on the backside of this form.</u>

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	
_____	____	____ F ____ M	_____	____ poor __ average __ good
_____	____	____ F ____ M	_____	____ poor __ average __ good

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	____ Muscular Dystrophy
___ Anemia	____ Diabetes	____ Nervousness
___ Anxiety	____ Glandular problems	____ Perceptual motor disorder
___ Asthma	____ Heart diseases	____ Problems in school
___ Autism	____ High blood pressure	____ Seizures
___ Blindness	____ Kidney disease	____ Substance Use
___ Cancer	____ Mental illness	____ Suicide
___ Cerebral Palsy	____ Mental retardation	____ Other (specify): _____
___ Deafness	____Migraines	_____

Comments re: Family Health: _____

Child's Medical/Physical Health

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

Please check any illnesses your child has had and list how old they were at that time:

___ Asthma	____Hayfever	____ Vision problems
___ Blackouts	____ Heart trouble	____ Nose bleeds
___ Bronchitis	____Lead poisoning	____ Other (please explain below)
___ Hives	___ Measles	
____ Chicken Pox	____ Pneumonia	
___ Diabetes	____ Seizures	
___ Diphtheria		
___ Ear infections	____ Nose bleeds	
___ Fevers	____ Thyroid disorders	

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 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 approximate age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____

Took 1st steps: _____ Spoke words: _____

Rode two-wheeled bike: _____ Spoke sentences: _____

Toilet trained: _____ Fed self: _____

Dry during day: _____ 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: _____
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: _____

Current concerns about child's performance in school: _____
_____
_____
_____

When did problems at school begin? _____
_____
_____

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

Do you have concerns about your child's peer relationships? _____

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

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, school activities, scouts, etc.)

Activity	How often do they participate?
_____	_____
_____	_____
_____	_____

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? __Yes __ No

If Yes, describe: _____

Counseling Treatment History

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

Current provider: _____ Phone number: _____

Date treatment began: _____ Frequency of treatment: _____

Focus of treatment/referral concerns: _____

_____

Any medication prescribed? ___ Yes ___ No If yes, name and dosage: _____

Prior counseling or psychiatric treatment:

Provider:_____ Phone number: _____

Date treatment began: _____ Length of treatment: _____

Focus of treatment/referral concerns: _____

_____

Any medication prescribed? ___ Yes ___ No If yes, name and dosage: _____

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

If yes, please explain when and why this hospitalization occurred: _____

_____

Behavioral/Emotional

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

Are your 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 your 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? (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: _____
_____

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 assist us in understanding your child/adolescent?
_____
_____