Personal History—Children and Adolescents

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	___ 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	___ Spinal 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 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: _____

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)