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Child & Adolescent Personal History

Client's name: _____ Today's Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____ Grade in school: _____

Form completed by: _____

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

Phone (home): _____ (work): _____ (cell): _____

Family History

Parents

With whom does your child live at this time? _____

Are parent's divorced or separated? _____

If yes, who has legal custody? _____

Have both of your child's parents signed consent for this treatment? _____

Were your child's parents ever married? ___ Yes ___ No

Is there any significant information about your child's parents' relationship or treatment toward your child that may be beneficial in counseling? Please, describe: _____

Client's Father

Name: _____ Age: _____ Occupation: _____ FT/PT

Where employed: _____ Father's email address: _____

Father's Phone (home): _____ (cell): _____ (work): _____

Father's education: _____

Is your child currently living with his or her father? ___ Yes ___ No

Is there anything notable, unusual or stressful about your child's relationship with his or her father?
___ Yes ___ No If yes, please explain: _____

How is your child disciplined by his or her father? _____

Client's Mother

Name: _____ Age: _____ Occupation: _____ FT/PT

Where employed: _____ Mother's email address: _____

Mother's Phone (home): _____ (cell): _____ (work): _____

Mother's education: _____

Is your child currently living with his or her mother? Yes No

Is there anything notable, unusual or stressful about your child's relationship with his or her mother?
 Yes No If yes, please explain: _____

How is your child disciplined by his or her mother? _____

People Currently Living in Your Child's Home

Names of Siblings	Age	Gender (circle)	Lives in home (circle)	Quality of relationship with your child (circle)
_____	_____	F/ M	Y/N	poor/average/good/excellent
_____	_____	F /M	Y/N	poor/average/good/excellent
_____	_____	F/M	Y/N	poor/average/good/excellent
_____	_____	F/M	Y/N	poor/average/good/excellent
_____	_____	F/M	Y/N	poor/average/good/excellent
_____	_____	F/M	Y/N	poor/average/good/excellent
_____	_____	F/M	Y/N	poor/average/good/excellent
_____	_____	F/M	Y/N	poor/average/good/excellent

Others living in your child's home	Age	Gender	Relationship (e.g., cousin, foster child)	Quality of relationship
_____	_____	F/M	_____	poor/average/good/excellent
_____	_____	F/M	_____	poor/average/good/excellent
_____	_____	F/M	_____	poor/average/good/excellent
_____	_____	F/M	_____	poor/average/good/excellent

Comments: _____

Family Health History

Is there any history of medical diseases or health concerns among your child's blood relatives? (parents, siblings, aunts, uncles or grandparents)? _____

Childhood/Adolescent History

Pregnancy/Birth

Mother's age at child's birth: _____ Father's age at child's birth: _____

How many pounds did your child's mother gain during her pregnancy with your child? _____

While pregnant with your child did your child's mother smoke? Yes No If yes, how much: _____

Did the mother use drugs of alcohol? Yes No If yes, type/amount consumed: _____

While pregnant, did your child's mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication)

Yes No If yes, please 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 your child's mother or your child after his or her birth: _____

Length of hospitalization: Mother: _____ Baby: _____

Infancy/Toddlerhood Check all which apply:

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Breast fed | <input type="checkbox"/> Milk allergies | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bottle fed | <input type="checkbox"/> Rashes | <input type="checkbox"/> Colic | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Not cuddly | <input type="checkbox"/> Cried often | <input type="checkbox"/> Rarely cried | <input type="checkbox"/> Overactive |
| <input type="checkbox"/> Resisted solid food | <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Irritable when awakened | <input type="checkbox"/> Lethargic |

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

Sat alone: _____ Dressed self: _____

Took 1st steps: _____ Tied shoe laces: _____

Spoke words: _____ Rode two-wheeled bike: _____

Spoke sentences: _____ Toilet trained: _____

Weaned: _____ Dry during day: _____

Fed self: _____ Dry during night: _____

Compared with others in your family, child's development was: _____ slow average fast

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

Education

Please list each school, grade level, and grading (e.g., As, Bs, Cs, Ds, or Fs) your child received:

Preschool _____

K _____

1st _____

2nd _____

3rd _____

4th _____

5th _____

6th _____

7th _____

8th _____

9th _____

10th _____

11th _____

12th _____

Does your child receive special education services? Describe. _____

Is your child on a 504 Accommodation Plan? Describe: _____

Has your school recently convened a Child Study Team meeting for your child? _____

Is your child educated in a gifted program? If yes, describe: _____

Has child ever been held back (retained) in school? If yes, describe: _____

What are your child's best subjects? _____

What are your child's worst subjects? _____

What grades does your child usually receive in school? _____

Have there been any recent changes in your child's grades? If yes, describe: _____

Has your child been tested by a school psychologist? If yes, describe: _____

Please describe any concerns you have about your child's school functioning, including academic, social, emotional, and behavioral progress: _____

If your child is employed or involved in a vocational program, please complete the following:

Describe your child's attitude toward work? _____ Poor _____ Average _____ Good _____ Excellent

Current employer: _____ Position: _____ Hours per week: _____

How have your child's grades in school been affected since working? _____ Lower _____ Same _____ Higher

How many previous jobs or placements has your 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

Does your child suffer from any significant health concerns? _____

Nutrition

Compared to other same-aged children how would you describe your child's eating habits? _____

Do you have any concerns about your child's eating habits? If yes, please describe: _____

Most recent examinations

Type of examination	Date of most recent visit	Results
Physical examination	_____	_____
Dental examination	_____	_____
Vision examination	_____	_____
Hearing examination	_____	_____

Prescribed medications (past or present)	Dose	Dates	Purpose	Benefits or side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Over-the-counter medications (current)	Dose	Dates	Purpose	Benefits or side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Chemical Use History

Do you think your child has a problem with alcohol or drug use? Yes No
 If Yes, describe: _____

Counseling/Prior Treatment History

Please complete this information about your child (past and present):

	Dates	Location/Practitioner	Overall experience/benefit
Counseling/Psychiatric Care	_____	_____	_____
Counseling/Psychiatric Care	_____	_____	_____
Counseling/Psychiatric Care	_____	_____	_____
Counseling/Psychiatric Care	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____
Psychiatric hospitalization	_____	_____	_____

Behavioral/Emotional

Please check any of the following that are typical for your child:

- | | | |
|---|---|---|
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Frustrated easily | <input type="checkbox"/> Sad |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Gambling | <input type="checkbox"/> Selfish |
| <input type="checkbox"/> Alcohol problems | <input type="checkbox"/> Generous | <input type="checkbox"/> Separation anxiety |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sets fires |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Head banging | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Attachment issues | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Sexual acting out |
| <input type="checkbox"/> Avoids adults | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Shares |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Hurts animals | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Blinking, jerking | <input type="checkbox"/> Imaginary friends | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Bizarre behavior | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Shy, timid |
| <input type="checkbox"/> Bullies, threatens | <input type="checkbox"/> Irritable | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Careless, reckless | <input type="checkbox"/> Lazy | <input type="checkbox"/> Slow moving |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Soiling |
| <input type="checkbox"/> Clumsy | <input type="checkbox"/> Lies frequently | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Confident | <input type="checkbox"/> Listens to reason | <input type="checkbox"/> Steals |
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Loner | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Suicidal threats |
| <input type="checkbox"/> Defiant | <input type="checkbox"/> Messy | <input type="checkbox"/> Suicidal attempts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Moody | <input type="checkbox"/> Talks back |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Obedient | <input type="checkbox"/> Thumb sucking |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Often sick | <input type="checkbox"/> Tics or twitching |
| <input type="checkbox"/> Drugs dependence | <input type="checkbox"/> Oppositional | <input type="checkbox"/> Unsafe behaviors |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Over active | <input type="checkbox"/> Unusual thinking |
| <input type="checkbox"/> Enthusiastic | <input type="checkbox"/> Over weight | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Excessive masturbation | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Expects failure | <input type="checkbox"/> Phobias | <input type="checkbox"/> Worries excessively |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Psychiatric problems | _____ |
| <input type="checkbox"/> Frequent injuries | <input type="checkbox"/> Quarrels | _____ |

Has your child experienced death? (friends, family pets, other) _____ Yes _____ No

At what age? _____ If Yes, describe your 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 your child's therapy? _____

What family involvement would you like in your child's therapy? _____

Do you believe your child is suicidal at this time? _____ Yes _____ No

If Yes, explain: _____

Name of Person(s) Completing This Form _____

Relationship to Patient _____