Michael Edward Tansy, PhD, ABPP
Licensed Psychologist
Fellow, American Psychological Association
Nationally Certified Counselor
Nationally Certified School Psychologist
Specialist, American Board of Professional Psychology
Member, American Academy of School Psychology
4140 East Baseline Road, Suite 101 Mesa, AZ 85206
Telephone: (480) 966-9337 Fax: (480) 704-5181 Email: drtansy@michaeltansy.com

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' 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:

_____ 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 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			

Psychiatric hospitalization _____

Behavioral/Emotional

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

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_____ Excessive masturbation	____ Panic attacks	____ Withdrawn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