

Personal History — Children and Adolescents

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Child'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): _____ (Parent work): _____ Cell _____

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
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
Others living in the household			Relationship (e.g., cousin, foster child)	
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> 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:

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Deafness | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glandular problems | <input type="checkbox"/> Perceptual motor disorder |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Heart diseases | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Spinal Bifida |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Cleft lips | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Multiple sclerosis | _____ |

Comments re: Family Health: _____

Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurrences 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: _____

On IEP or special education? Yes No 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: Please check any items below that are historical or current health concerns

- | | | |
|--|---|---|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Hayfever | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hives | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Influenza | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Lead poisoning | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Congenital problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Severe colds |
| <input type="checkbox"/> Croup | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Severe head injury |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mumps | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Ear aches | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Wearing glasses |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Other skin rashes | <input type="checkbox"/> Other |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Paralysis | _____ |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Pleurisy | _____ |

List any current health concerns: _____

List any recent health or physical changes: _____

Nutrition

Meal	How often	Typical foods eaten	Typical amount eaten			
	(times per week)		No	Low	Med	High
Breakfast	____ / week	_____	____	___	___	___
Lunch	____ / week	_____	____	___	___	___
Dinner	____ / week	_____	____	___	___	___
Snacks	____ / week	_____	____	___	___	___

Comments: _____

Most Recent Examinations

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

	Dose	Dates	Purpose	Side effects
Current prescribed medications				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

	Dose	Dates	Purpose	Side effects
Current over-the-counter meds				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Immunization Record (check immunizations the child/adolescent has received):

	DPT	Polio	
2 months	___	___	15 months ___ MMR (Measles, Mumps, Rubella)
4 months	___	___	24 months ___ HBPV (Hib)
6 months	___	___	Prior to school ___ HepB
18 months	___	___	
4-5 years	___	___	

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:

- | | | |
|---|---|---|
| <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 to dolls | <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"/> Overweight | <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 | _____ |

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/homicidal at this time? _____ Yes _____ No
If Yes, explain: _____

For Staff Use

Therapist's comments: _____

Physical exam: _____ Required ___ Not required

Date: _____

Beth Doyle, LPC: _____

This certifies the case assignment, level of care and need for exam