

## Personal History—Children and Adolescents (<18)

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 behaviorogrs \_\_\_\_\_ 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:

- Allergies
- Anemia
- Asthma
- Bleeding tendency
- Blindness
- Cancer
- Cerebral Palsy
- Cleft lips
- Cleft palate
- Deafness
- Diabetes
- Glandular problems
- Heart diseases
- High blood pressure
- Kidney disease
- Mental illness
- Migraines
- Multiple sclerosis
- Muscular Dystrophy
- Nervousness
- Perceptual motor disorder
- Mental Retardation
- Seizures
- Spinal Bifida
- Suicide
- Other (specify): \_\_\_\_\_

Comments re: Family Health: \_\_\_\_\_

\_\_\_\_\_

**Childhood/Adolescent History**

**Pregnancy/Birth**

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: \_\_\_\_\_

**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): \_\_\_\_\_

**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

- |  |   |   |
|--|---|---|
| <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: \_\_\_\_\_

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

**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 me in understanding your child/adolescent?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Any additional information that would assist me 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 Office Use Only**

Therapist's comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Therapist's signature/credentials: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Physical Exam: \_\_\_\_\_ Required \_\_\_\_\_ Not required