

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? _____

Where the child's parents ever married? ___ Yes ___ No

Is there any significant information about the parents' relationship or treatment of child that the therapist should know/understand? ___ 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 ___ Stepparent ___ 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 Stepparent Adoptive parent Foster home Other (specify): _____

If 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

Name 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
_____		F M	home	away	poor	average	good

Others living in. the household	Gender	Relationship (e.g., cousin, foster child)	Quality of Relationship
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_____ 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:

<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"/> Spina 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	_____
<input type="checkbox"/> Comments re: Family Health: _____		

CHILDHOOD/ADOLESCENT HISTORY

PREGNANCY/BIRTH

Has the child's mother had any occurrences of miscarriages or stillbirths? 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:

- | | | | |
|--|---|--|---------------------------------------|
| <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 shoelaces: _____

Spoke words: _____ Rode two-wheel 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 that specifically relate to your child.

FEELINGS ABOUT SCHOOLWORK:

___ Anxious ___ Passive ___ Enthusiastic ___ Fearful
___ Eager ___ No expression ___ Bored ___ Rebellious

___ Other (describe): _____

APPROACH TO SCHOOLWORK:

___ 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 ___ Longtime 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 ___ Hay fever ___ Pneumonia
___ Asthma ___ Heart trouble ___ 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"/> Earaches | <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Wearing glasses |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Nosebleeds | <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 (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High
Lunch	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High
Dinner	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High
Snacks	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> 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	___	___	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"/> Stomachaches |
| <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"/> Drug dependence | <input type="checkbox"/> Oppositional | <input type="checkbox"/> Unsafe behaviors |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Overactive | <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?

Additional information that would assist us in understanding current concerns or problems (List)

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: _____

Who referred you? _____

Please Bring to Session with you.