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): _____

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): _____

_____

CULTURAL/ETHNIC

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues?____Yes_____No

If Yes, describe: _____

Other cultural/ethnic information: _____

SPIRITUAL/RELIGIOUS

How important to you are spiritual matters?____Not ____ Little ____ Moderate_____Much

Are you affiliated with a spiritual or religious group?____Yes_____No

If Yes, describe: _____

Were you raised within a spiritual or religious group?____Yes_____No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling?____Yes_____No

If Yes, describe: _____

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 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___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 : _____

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? _____

_____

For what reasons is the child disciplined by the mother? _____

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

Comments: _____

_____

_____

WOODBRIDGE THERAPY GROUP

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	____ Deafness	____ Muscular dystrophy
____ Anemia	____ Diabetes	____ Nervousness
____ Asthma	____ Glandular problems	____ Perceptual motor disorder
____ Bleeding tendency	____ Heart diseases	____ Mental retardation
____ Blindness	____ High blood pressure	____ Seizures
____ Cancer	____ Kidney disease	____ Spina bifida
____ Cerebral palsy	____ Mental illness	____ Suicide
____ Cleft lips	____ Migraines	____ Other (specify): _____
____ Cleft palate	____ Multiple sclerosis	_____

____ 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:

___ 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-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): _____

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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:_____

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
___ Asthma
___ Blackouts
___ Bronchitis
___ Cerebral palsy
___ Chicken pox
___ Congenital problems
___ Croup
___ Diabetes
___ Diphtheria
___ Dizziness
___ Earaches
___ Ear infections
___ Eczema
___ Encephalitis
___ Fevers
___ Hay fever
___ Heart trouble
___ Hepatitis
___ Hives
___ Influenza
___ Lead poisoning
___ Measles
___ Meningitis
___ Miscarriage
___ Multiple sclerosis
___ Mumps
___ Muscular dystrophy
___ Nosebleeds
___ Other skin rashes
___ Paralysis
___ Pleurisy
___ Pneumonia
___ Polio
___ Pregnancy
___ Rheumatic fever
___ Scarlet fever
___ Seizures
___ Severe colds
___ Severe head injury
___ Sexually transmitted disease
___ Thyroid disorders
___ Vision problems
___ Wearing glasses
___ Whooping cough
___ Other
_____

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

NUTRITION

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

Comments: _____

MOST RECENT EXAMINATIONS

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

Please list all medications

Current prescribed meds	Dose	Dates	Purpose	Side effects

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:

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

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 at this time?___Yes_____No

If Yes, explain:

FOR STAFF USE

Therapist's comments:

Therapist's signature/credentials:_____ Date: _/ _/____