Form 22 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 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
_________________	____	____ 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			Relationship (e.g., cousin, foster child)	
_________________	____	____ F ____ M	__________________	___ poor ___ average ___ good
_________________	____	____ F ____ M	__________________	___ poor ___ average ___ good
_________________	____	____ 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:

___ 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	____ Spinal 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 occurances 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: ________________________

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): ____

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

___ Abortion	____ Hayfever	____ Pneumonia
___ Asthma	____ Heart trouble	____ Polio
___ Blackouts	____ Hepatitis	____ Pregnancy
___ Bronchitis	____ Hives	____ Rheumatic Fever
___ Cerebral Palsy	____ Influenza	____ Scarlet Fever
___ Chicken Pox	____ Lead poisoning	____ Seizures
___ Congenital problems	____ Measles	____ Severe colds
___ Croup	____ Meningitis	____ Severe head injury
___ Diabetes	____ Miscarriage	____ Sexually transmitted disease
___ Diphtheria	____ Multiple sclerosis	____ Thyroid disorders
___ Dizziness	____ Mumps	____ Vision problems
___ Ear aches	____ Muscular Dystrophy	____ Wearing glasses
___ Ear infections	____ Nose bleeds	____ Whooping cough
___ Eczema	____ Other skin rashes	____ Other
___ Encephalitis	____ Paralysis	____________________________
___ Fevers	____ 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	______________________	____ 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	____________	____________

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	___	____
MMR (Measles, Mumps, Rubella)		
4 months	___	____
HBPV (Hib)		
6 months	___	____
HepB		
18 months	___	____
4–5 years	___	____

15 months ____________________

24 months ____________________

Prior to school ____________________

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
___ Drugs 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
____ Over active
____ 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
____ Stomach aches
____ 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: _____/____/______

Supervisor's comments: ____

____

____

____

____________________________________ Physical exam: ________ Required ____ Not required

Supervisor's signature/credentials: __________________________________ Date: _____/____/______

(Certifies case assignment, level of care and need for exam)