Counseling and Behavioral Solutions, Inc.

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? _____

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 **Biological: _____** **Adopted: _____**

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.

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: _____

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 check which applies:

	Early	**Normal**	**Late**
Sat alone			
Took 1st steps			
Spoke words			
Spoke sentences			
Weaned			
Fed self			
Dressed self			
Tied shoelaces			
Rode two-wheeled bike			
Toilet trained			

Dry during day			
Dry during night			

Compared with others in the family, child's development was: __ slow ____ average ____ fast

Age for following (fill in where applicable)

Began puberty: _____ Menstruation: _____

Voice change: _____ Convulsions: _____

Breast development: _____ Injuries or hospitalization: _____

Issues that affected child's development:

Explain:

Physical Abuse	
Sexual Abuse	
Inadequate nutrition	
Neglect	
Trauma	
Death in Family	
Other	

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
___ Asthma
___ Blackouts
___ Bronchitis
___ Cerebral Palsy
___ Chicken Pox
___ Congenital problems
___ Croup
___ Diabetes
___ Diphtheria
___ Dizziness
___ Ear aches
____ Hayfever
____ Heart trouble
____ Hepatitis
____ Hives
____ Influenza
____ Lead poisoning
____ Measles
____ Meningitis
____ Miscarriage
____ Multiple sclerosis
____ Mumps
____ Muscular Dystrophy
____ Pneumonia
____ Polio
____ Pregnancy
____ Rheumatic Fever
____ Scarlet Fever
____ Seizures
____ Severe colds
____ Severe head injury
____ Sexually transmitted disease
____ Thyroid disorders
____ Vision problems
____ 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	Typical amount eaten (check which applies)			
Breakfast	_____ No	_____Low	_____ Med	____ High
Lunch	_____ No	_____ Low	_____ Med	____ High
Dinner	_____ No	_____ Low	_____ Med	____ High
Snacks	_____ No	_____ Low	_____ Med	____ High

Concerns with food: _____

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

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

Reviewed by: _____ Date: ____/____/_____