Personal History Form—Child (<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 mother?

____ 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
___ 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

Has the child's mother had any occurrences 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 shoe laces: _____

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	____Hay fever	____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	____	____
4 months	____	____
6 months	____	____
18 months	____	____
4–5 years	____	____

15 months _____ MMR (Measles, Mumps, Rubella)

24 months ____ HBPV (Hib)

Prior to school ____ HepB

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
____Over weight
____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: _____/_____/_____