Case Name: ____

CHILD / ADOLESCENT HISTORY

Date: ____/______/_____

Child's Name: ____Date of Birth: ______________

Person completing form: ____________________________________ Relationship to child: _______________

Current Symptoms:

1. Please circle all that apply to your current problem:

Aggression	Lack of Friends	
Anger Outbursts	Fears	School Problems
Absences from School	Hyperactivity	Lack of self-control
Eats Too Much	Headaches	Sensitive
Eats Too Little	Health Problems	Sadness
Behavior Problems	Homework Problems	Shyness
Bladder Control Problems	Irritable	Stealing
Bowel Control Problems	Insecure	Stress
Poor Concentration	Loneliness	Suicidal Thoughts
Crying Spells	Nervous	Temper Tantrums
Delinquent Friends	Nightmares	Uncooperative
Lack of Energy	Running Away	Withdrawn

2. Please add detail to any of the above, and comment here:

3. What have you tried to help with the problems (was/wasn't helpful)?

Previous Counseling Information:
Has your child had previous counseling, in-patient or outpatient? ☒Yes ☒No

If yes, describe provider and dates of treatment:

Describe your child's previous counseling experience

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MEDICAL HISTORY:

Date of patient's last physical exam: ___/_____/____

Name of child's physician: __________________________________ Phone: ____________________________

Address: ____

A. History of illnesses and/or accidents:

1. Is your child taking medication now? ☒Yes ☒No
If yes, list dosage and when started

2. Has your child been on any medication within the past 6 months? ☒ Yes ☒ No

If yes, list dosage and when started:

3. Is your child having any allergies? ☒ Yes ☒ No

Describe:

4. Has your child ever been hospitalized (injuries, operations, serious accidents)? ☒ Yes ☒ No

If so, what / when?

5. Does your child have any physical or neurological handicaps, including hearing or vision loss? ☒Yes ☒No

If yes, please specify:

6. Do you believe your child has a medical problem, which may not be identified? ☒ Yes ☒ No

If so, describe symptoms:

7. Has your child had any developmental problems? (i.e. motor coordination, visual, speech, learning, or language?

☒Yes ☒No

If yes, please specify:

8. At what age was your child potty trained? _________ Has your child had problems with bladder control?

Day: ☒Yes ☒ No Night: ☒ Yes ☒ No Bowel control? Day: ☒Yes ☒ No Night: ☒ Yes ☒ No

9. What is your child's sleeping patterns like? Check those which apply:

☒ awakening from sleep ☒ sleepwalking ☒ bedwetting

☒ appearing to be awake but not awake ☒ nightmares ☒ sleeps through the night?

Describe:

Case Name: ____

DEVELOPMENTAL HISTORY

Prenatal:

1. Was the mother's physical health good during the pregnancy? ☒Yes ☒No

2. Was the mother on any medication during the pregnancy? ☒Yes ☒No
If yes, please specify:

3. Was the mother taking drugs or alcohol during pregnancy? ☒Yes ☒No
If yes, please specify:

4. Were there any severe emotional stresses during this pregnancy? ☒Yes ☒No
If yes, please specify:

5. Was this pregnancy planned? ☒Yes ☒No

6. Did the mother look forward to this child's birth? ☒Yes ☒ No

7. Did the father look forward to this child's birth? ☒ Yes ☒ No

Birth and Infancy:

1. Was your child's delivery normal? ☒Yes ☒No

   If no, please specify:

2. Was the pregnancy full term? ☒Yes ☒No If no, was the infant hospitalized? __________

   What was the birth weight? __________

4. Did the mother experience the "blues" after delivery? ☒Yes ☒ No

5. Describe what it was like to care for your child as an infant? Check those which apply:
   ☒ Liked to be held ☒ Easy going
   ☒ Cried a lot ☒ Very active
   ☒ Difficult to comfort ☒ Other: ____

6. If the father was in the home at the time, did he participate in caring for the baby? ☒Yes ☒No

7. Would you describe your child's development as normal? ☒Yes ☒ No

If no, please specify:

Later Years:

1. Is your child's social behavior appropriate for his/her age (i.e. same age friends?
   ☒ Yes ☒ No Comment:

2. Describe your child in group situations (circle traits): shy outgoing follower
   loner leader few friends many friends gang involvement

3. Do you have a religious preference? ☒ Yes ☒ No

   If yes, what?

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4. Does your child relate comfortably with members of his/her own sex? ☒Yes ☒ No

5. Have you ever had any indications that your child may have been sexually molested?

☒ Yes ☒ No Comments: ____

6. Have you ever had any indications that your child may have been physically abused?

☒Yes ☒ No Comments: ____

7. Has your child been sexually active? ☒ Yes ☒ No Pregnancies? ☒ Yes ☒ No

8. Has your child been involved in any substance abuse (i.e., drugs, alcohol, etc.)? ☒Yes ☒ No

If yes, name substance (i.e. alcohol, marijuana) and frequency of use (if known): ______________

Substance	Date last used	Amount	Frequency	# of years used

11. Describe any self-harming or suicidal tendencies or behaviors (i.e. cutting on self, threats):

SCHOOL HISTORY:

1. Does your child enjoy school? ☒ Yes ☒ No

2. Does your child complete his/her work assignments on time? ☒ Yes ☒No

3. Is studying a problem for your child? ☒Yes ☒No

4. Is your child having behavioral problems at school? ☒Yes ☒ No

5. Is your child achieving at expected level? ☒Yes ☒ No

6. Please circle the word that best describes your child's grades:
Superior Above Average Average Below average Failing

7. Does your child belong to any social or athletic groups? ☒Yes ☒ No
If yes, specify:

PSYCHOLOGICAL STRESSORS:

Please circle:

Move(s)	Yes	No	Age______
Death of family member	Yes	No	Age______
Birth of sibling	Yes	No	Age______
Separation	Yes	No	Age______
Divorce	Yes	No	Age______
Major illness	Yes	No	Age______
Other: _____________	Yes	No	Age______

How did your child react to each of these changes? Describe:

Case Name: ____

FAMILY INFORMATION
Please give the full name and age of everyone currently in the household.

Name: ______________________ Age ____________________ Relationship to child ______________

____

____

____

Please give the full name and age of parents and siblings not currently living in the household:

Name: ______________________ Age ____________________ Relationship to child ______________

____

____

____

BRIEF DESCRIPTION OF CURRENT HOME LIFE

1. What things are done together as a family in your home? Explain:

2. How often does your child participate in these activities?

3. In your opinion, what family activity is most valued by your child?

4. If your family had a motto, what would it be?

5. Has anyone other than parents and children lived in your home for an extended period of time? If yes, please describe who and when:

6. Is there any alcoholism or drug abuse in your family? ☐ Yes ☐ No

   If yes, please describe who and when:

7. Which below best characterizes the overall home environment of the child currently:

_____ Unconditional love and acceptance; close relationships

_____ Quiet and peaceful, but relationships are distant

_____ Instability, periods of peace mixed with periods of fighting

_____ Family fighting or arguing the norm

_____ Other: ____

8. How would you describe the child's parent's co-habitation or co-parenting arrangement:

_____ Very much in love; best of friends; happy

_____ Committed to one another, but could be closer/happier

_____ Unhappy, but trying to make the best of it

_____ Unhappy, avoid one another and keep fights secret from children most of the time.

_____ Unhappy, much fighting together, often in front of children

_____ Separated or divorced, congenial

_____ Separated or divorced, antagonistic

_____ Other: ____

Case Name: ____

9. Does your child have any present hobbies, interests, or uses of free time? If yes, describe:

10. Who does your child feel the closest to in the family? ____

11. Who are the adults or role models your child is close to outside the immediate family? __________________________

12. In solving family conflicts, sometimes different styles are used.

Circle the style which best describes family members currently living in your home:

Father:	Win	Compromise	Avoid	Withdraw	Resolve
Mother:	Win	Compromise	Avoid	Withdraw	Resolve
Child:	Win	Compromise	Avoid	Withdraw	Resolve

13. Who has the strongest influence in your family? ____

14. How well does your child confide in you? ____

15. What subjects are difficult for your child to discuss with you? ____

____

16. What is the parents' style of discipline? Circle the best fit:

Mother: Strict Firm & Loving Lenient No limits

Explain:

Father: Strict Firm & Loving Lenient No limits

Explain:

16. If the child was/is not being brought up by the parents, who did/is doing the child -rearing?
____________________________________How old was the child when this occurred? ________

17. Has any member of your family or extended family suffered anything, which might be considered a "mental disorder" or any other illness that might be relevant?

If so, who / what?

Please describe any relevant circumstances to the child’s living or interacting with this family member:

Case Name: ______________________________________

SUMMARY OF CURRENT PROBLEM

1. How does the child feel about counseling at this time?

2. What specifically would you and/or your child like to see happen as a result of counseling?

3. Are the parents open to learning new parenting skills?

4. Is anyone else in the family currently involved in counseling, or in need of counseling?

5. Is there any information or comments you would like to add?

Thank you, for taking the time to complete this information.
We look forward to working with you.