CHILD HISTORY

Name: _____ **Date of Birth:**_____

If you need more space to answer 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 parents divorced or separated? _____

If yes, who has legal custody? _____

We're the child's parents ever married? ___ Yes ___ No

Is there any significant information about the parent's relationship or treatment towards the child which might be beneficial in counseling? ___ Yes ___ No

If yes, describe: _____

_____

Client's Mother

Name: _____ Age: _____ Occupation: _____ ___ FT ___ PT

Where employed: _____ Mother's education: _____

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? _____

CHILD HISTORY

Client's Father

Name: _____ Age: _____ Occupation: _____ ___ FT ___ PT

Where employed: _____ Father's education: _____

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? _____

Other Members of the Home

Name	Age	Gender	Relationship to Client	Quality of relationship with client
_____	___	_____	_____	___ poor ___ average ___ good
_____	___	_____	_____	___ poor ___ average ___ good
_____	___	_____	_____	___ poor ___ average ___ good
_____	___	_____	_____	___ poor ___ average ___ good
_____	___	_____	_____	___ poor ___ average ___ good
_____	___	_____	_____	___ poor ___ average ___ good
_____	___	_____	_____	___ poor ___ average ___ good
_____	___	_____	_____	___ 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

CHILD HISTORY

__ Asthma
__ Bleeding tendency
__ Blindness
__ Cancer
__ Cerebral Palsy
__ Cleft Lips
__ Cleft palate
__ Glandular problems
__ Heart disease
__ High blood pressure
__ Kidney disease
__ Mental Illness
__ Migraines
__ Multiple sclerosis
__ Perceptual motor DO
__ Mental Retardation
__ Seizures
__ Spinal Bifida
__ Suicide
__ Other (specify)_____
_____

Comments re: Family Health: _____

_____

Child/Adolescent History

Birth

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 or alcohol? ____ Yes ____ No If yes, what 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 baby after the birth: _____

_____

Length of hospitalization: Mother _____ Baby _____

Developmental History

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

CHILD HISTORY

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

_____

_____

Education

Current school: _____

Type of school: ___ Public ___ Private ___ Homeschooled ___ Other (specify) _____

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): _____

CHILD HISTORY

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 has 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?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHILD HISTORY

Medical/Physical Health

___ Abortion
___ Asthma
___ Blackouts
___ Bronchitis
___ Cerebral Palsy
___ Chicken Pox
___ Congenital problems
___ Croup
___ Diabetes
___ Diphtheria
___ Dizziness
___ Ear aches
___ Ear infections
___ Eczema
___ Encephalitis
___ Fevers
___ Hay fever
___ Heart trouble
___ Hepatitis
___ Hives
___ Influenza
___ Lead poisoning
___ Measles
___ Meningitis
___ Miscarriage
___ Multiple sclerosis
___ Mumps
___ Muscular Dystrophy
___ Nose bleeds
___ 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: _____

_____

Most recent examinations

Type of examination	Most recent visit	Results
Physical		
Dental		
Vision		
Hearing		

CHILD HISTORY

Current prescribed medications	Dose	Dates	Purpose	Side effects

Over the counter medications	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	____	____	_____	_____	_____

CHILD HISTORY

Behavioral/Emotional

___ 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
___ 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
___ 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

CHILD HISTORY

___ Expects failure ___ Phobias ___ Worries excessively

___ Fatigue ___ Poor appetite ___ Other

___ Fearful ___ Psychiatric problems _____

___ Frequent injuries ___ Quarrels _____

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?

_____

_____

_____

CHILD HISTORY

What are your goals for the child's therapy? _____

_____

What family involvement would you like to see in therapy? _____

_____

Do you believe the child is suicidal at this time? ___ Yes ___ No

If yes, explain: _____

_____

CHILD HISTORY