Personal History – Children, and Adolescents – HCC

Patient's name: _____ Date: _____
Gender: Female Male 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	___	____	15 months ____	MMR (Measles, Mumps, Rubella)
4 months	___	___	24 months ____	HBPV (Hib)
6 months	___	___	Prior to school _____	HepB
18 months	___	___		
4–5 years	___	___		

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: ___/_____/_____

_____ Physical exam: _____ Required __ Not required