

## 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
- \_\_\_ 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:

- |  |   |  |                                       |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Breast fed          | <input type="checkbox"/> Milk allergies   | <input type="checkbox"/> Vomiting                | <input type="checkbox"/> Diarrhea     |
| <input type="checkbox"/> Bottle fed          | <input type="checkbox"/> Rashes           | <input type="checkbox"/> Colic                   | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Not cuddly          | <input type="checkbox"/> Cried often      | <input type="checkbox"/> Rarely cried            | <input type="checkbox"/> Overactive   |
| <input type="checkbox"/> Resisted solid food | <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Irritable when awakened | <input type="checkbox"/> 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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Abortion            | <input type="checkbox"/> Hayfever           | <input type="checkbox"/> Pneumonia                    |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Heart trouble      | <input type="checkbox"/> Polio                        |
| <input type="checkbox"/> Blackouts           | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Pregnancy                    |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Hives              | <input type="checkbox"/> Rheumatic Fever              |
| <input type="checkbox"/> Cerebral Palsy      | <input type="checkbox"/> Influenza          | <input type="checkbox"/> Scarlet Fever                |
| <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Lead poisoning     | <input type="checkbox"/> Seizures                     |
| <input type="checkbox"/> Congenital problems | <input type="checkbox"/> Measles            | <input type="checkbox"/> Severe colds                 |
| <input type="checkbox"/> Croup               | <input type="checkbox"/> Meningitis         | <input type="checkbox"/> Severe head injury           |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Diphtheria          | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Thyroid disorders            |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Vision problems              |
| <input type="checkbox"/> Ear aches           | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Wearing glasses              |
| <input type="checkbox"/> Ear infections      | <input type="checkbox"/> Nose bleeds        | <input type="checkbox"/> Whooping cough               |
| <input type="checkbox"/> Eczema              | <input type="checkbox"/> Other skin rashes  | <input type="checkbox"/> Other                        |
| <input type="checkbox"/> Encephalitis        | <input type="checkbox"/> Paralysis          | _____   |
| <input type="checkbox"/> Fevers              | <input type="checkbox"/> 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:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Affectionate           | <input type="checkbox"/> Frustrated easily    | <input type="checkbox"/> Sad                  |
| <input type="checkbox"/> Aggressive             | <input type="checkbox"/> Gambling             | <input type="checkbox"/> Selfish              |
| <input type="checkbox"/> Alcohol problems       | <input type="checkbox"/> Generous             | <input type="checkbox"/> Separation anxiety   |
| <input type="checkbox"/> Angry                  | <input type="checkbox"/> Hallucinations       | <input type="checkbox"/> Sets fires           |
| <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Head banging         | <input type="checkbox"/> Sexual addiction     |
| <input type="checkbox"/> Attachment to dolls    | <input type="checkbox"/> Heart problems       | <input type="checkbox"/> Sexual acting out    |
| <input type="checkbox"/> Avoids adults          | <input type="checkbox"/> Hopelessness         | <input type="checkbox"/> Shares               |
| <input type="checkbox"/> Bedwetting             | <input type="checkbox"/> Hurts animals        | <input type="checkbox"/> Sick often           |
| <input type="checkbox"/> Blinking, jerking      | <input type="checkbox"/> Imaginary friends    | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Bizarre behavior       | <input type="checkbox"/> Impulsive            | <input type="checkbox"/> Shy, timid           |
| <input type="checkbox"/> Bullies, threatens     | <input type="checkbox"/> Irritable            | <input type="checkbox"/> Sleeping problems    |
| <input type="checkbox"/> Careless, reckless     | <input type="checkbox"/> Lazy                 | <input type="checkbox"/> Slow moving          |
| <input type="checkbox"/> Chest pains            | <input type="checkbox"/> Learning problems    | <input type="checkbox"/> Soiling              |
| <input type="checkbox"/> Clumsy                 | <input type="checkbox"/> Lies frequently      | <input type="checkbox"/> Speech problems      |
| <input type="checkbox"/> Confident              | <input type="checkbox"/> Listens to reason    | <input type="checkbox"/> Steals               |
| <input type="checkbox"/> Cooperative            | <input type="checkbox"/> Loner                | <input type="checkbox"/> Stomach aches        |
| <input type="checkbox"/> Cyber addiction        | <input type="checkbox"/> Low self-esteem      | <input type="checkbox"/> Suicidal threats     |
| <input type="checkbox"/> Defiant                | <input type="checkbox"/> Messy                | <input type="checkbox"/> Suicidal attempts    |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Moody                | <input type="checkbox"/> Talks back           |
| <input type="checkbox"/> Destructive            | <input type="checkbox"/> Nightmares           | <input type="checkbox"/> Teeth grinding       |
| <input type="checkbox"/> Difficulty speaking    | <input type="checkbox"/> Obedient             | <input type="checkbox"/> Thumb sucking        |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Often sick           | <input type="checkbox"/> Tics or twitching    |
| <input type="checkbox"/> Drugs dependence       | <input type="checkbox"/> Oppositional         | <input type="checkbox"/> Unsafe behaviors     |
| <input type="checkbox"/> Eating disorder        | <input type="checkbox"/> Over active          | <input type="checkbox"/> Unusual thinking     |
| <input type="checkbox"/> Enthusiastic           | <input type="checkbox"/> Overweight           | <input type="checkbox"/> Weight loss          |
| <input type="checkbox"/> Excessive masturbation | <input type="checkbox"/> Panic attacks        | <input type="checkbox"/> Withdrawn            |
| <input type="checkbox"/> Expects failure        | <input type="checkbox"/> Phobias              | <input type="checkbox"/> Worries excessively  |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Poor appetite        | <input type="checkbox"/> Other:               |
| <input type="checkbox"/> Fearful                | <input type="checkbox"/> Psychiatric problems | _____   |
| <input type="checkbox"/> Frequent injuries      | <input type="checkbox"/> 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?  
\_\_\_\_\_  
\_\_\_\_\_

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

