Forward Choices, LLC

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Personal History—Children and Adolescents (<18)

Client's name: ______________________________ Date: __________

Gender: ___ F ___ M Date of birth: __________ Age: __________

Name of school: ______________________________ Grade: __________

Address: __________________ City: __________ State: _____ Zip: ________

Phone (home): ________________ (work): ______________ Ext: __________

Form completed by (if someone other than client): ____________________

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: ______________________________

___ 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: ____

____ 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

Name	Age	Gender	Lives with client Y/N	Quality of relationship: Good, Fair, Poor

Others living in the house hold.

Name/Relationship	Age	Gender	Lives with client Y/N	Quality of relationship: Good, Fair, Poor

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 ____ 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 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 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: _________ Issues related to puberty: _____________________________

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?

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Medical/Physical Health

___ Abortion
___ Asthma
___ Blackouts
___ Bronchitis
___ Cerebral Palsy
___ Chicken Pox
___ Congenital problems
___ Croup
___ Diabetes
___ Diphtheria
___ Dizziness
___ Ear aches
___ Ear infections
___ Eczema
___ Encephalitis
___ Other
___ Hay fever
___ Heart trouble
___ Hepatitis
___ Hives
___ Influenza
___ Lead poisoning
___ Measles
___ Meningitis
___ Miscarriage
___ Multiple sclerosis
___ Mumps
___ Muscular Dystrophy
___ Nose bleeds
___ Other skin rashes
___ Paralysis
___ Pneumonia
___ Polio
___ Pregnancy
___ Rheumatic Fever
___ Scarlet Fever
___ Seizures
___ Severe colds
___ Severe head injury
___ STD
___ Thyroid disorders
___ Vision problems
___ Wearing glasses
___ Whooping cough
___ Pleurisy
___ Fevers

List any current health concerns: ____

____

List any recent health or physical changes: ____

____

Nutrition

Meal	How often.	Typical foods eaten:	Typical amount eaten:
Breakfast	___/Week		None/Less/Average/More
Lunch	___/Week		None/Less/Average/More
Dinner	___/Week		None/Less/Average/More
Snacks	___/Week		None/Less/Average/More

Comments: ____

____

Most recent examinations

Type of examination:	**Date of most recent visit:**	**Results:**
Physical Examination		
Dental Examination		
Vision Examination		
Hearing Examination		
Health Check		

Current prescribed medications

Medication and dose:	Date prescribed:	Purpose:	Side effects:

Current over-the-counter meds

Medication and dose:	How often used:	Purpose:	Side effects:

Immunization record (List immunizations the child/adolescent has received):

Chemical Use History

Does the child/adolescent use or have a problem with nicotine, alcohol or drugs?

Yes No

If Yes, describe (first use, frequency of use, last use, amount of substance typically used etc…): ______________________________

____

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

Treatment:	Yes/No	Dates	Where, and overall progress:
Outpatient Counseling and Psychiatric Treatment.			
Suicidal thoughts/attempts			
Drug/alcohol treatment			
Hospitalizations			

Community Resources

Please describe any community resources (support groups, social services, School based services)that have been utilized in the past year. ________________________

____

____

Behavioral/Emotional

Please check any of the following that are typical for your child:

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

Guardian Signature: ______________________________ Date: _______________

Client Signature: ______________________________ Date: _______________

For Staff Use

Therapist's comments: ____

____

Therapist's Name:______________________________________

Therapist's signature/credentials: ____________________________________

Date: _____/_____/_____