



## Personal History—Children and Adolescents

Client's name: \_\_\_\_\_ Date: \_\_\_\_\_  
Gender: \_\_\_ F \_\_\_ M 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
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
Others living in the household			Relationship (e.g., cousin, foster child)	
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> 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:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Deafness            | <input type="checkbox"/> Muscular Dystrophy        |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Nervousness               |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Glandular problems  | <input type="checkbox"/> Perceptual motor disorder |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Heart diseases      | <input type="checkbox"/> Mental Retardation        |
| <input type="checkbox"/> Blindness         | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures                  |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> Spinal Bifida             |
| <input type="checkbox"/> Cerebral Palsy    | <input type="checkbox"/> Mental illness      | <input type="checkbox"/> Suicide                   |
| <input type="checkbox"/> Cleft lips        | <input type="checkbox"/> Migraines           | <input type="checkbox"/> Other (specify): _____    |
| <input type="checkbox"/> Cleft palate      | <input type="checkbox"/> 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 or 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?

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Any additional information that would assist us in understanding current concerns or problems?

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What are your goals for the child's therapy? \_\_\_\_\_

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What family involvement would you like to see in the therapy? \_\_\_\_\_

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

If Yes, explain: \_\_\_\_\_

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