CHILD & ADOLESCENT HISTORY

Parent, please fill in completely. Rev. 1/2004

Name of Child/Adolescent: _____

Date of Birth: _____ Age: _____ Sex: ____ Soc. Security Number: _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Parent's Work Phone: _____

FAMILY INFORMATION

Father _____ Age _____ Occupation _____

Religion _____ Education _____ Married_____ Divorced _____ Deceased _____
Year Year Year

Mother _____ Age _____ Occupation _____

Religion _____ Education _____ Married_____ Divorced _____ Deceased _____
Year Year Year

Stepfather _____ Age _____ Occupation _____

Religion _____ Education _____ Married_____ Divorced _____ Deceased _____
Year Year Year

Stepmother _____ Age _____ Occupation _____

Religion _____ Education _____ Married_____ Divorced _____ Deceased _____
Year Year Year

Legal Guardian: _____ _____
Name Relationship

Address: _____ City: _____ State: _____ Zip: _____

Brothers and Sisters			
Name	Sex	Age	Where they are now living

Other People Living in the Home			
Name	Sex	Age	Relation to Child/Adolescent

Is your child/adolescent adopted? Yes _____ No _____ Circumstances:_____

Family history of mental/emotional problems (describe): _____

Family history of alcohol or drug problems (describe): _____

Family history of legal problems (describe): _____

Family history of suicide attempts (describe): _____

PREGNANCY

Describe mother's health during pregnancy: _____

What drugs (including alcohol) were taken during pregnancy? _____

Stress experienced during pregnancy: _____

BIRTH & EARLY DEVELOPMENT

How long did labor last? _____ Labor induced? _____ Caesarian birth? _____ Full-term? _____

Child's Birth weight: _____ Problems breathing? _____ Treatments: _____

Was baby breast-fed, bottle-fed or both? _____ Problems with nursing or formula: _____

Age baby completely weaned: _____ Describe baby's activity level: _____

Stressful events in family during baby's first year: _____

CHILD DEVELOPMENT

At what age did child first walk without support? _____

At what age did child first speak words? _____ Simple sentences? _____

Did child have difficulty speaking? _____ Age: _____ Speech therapy? _____

Age child stopped wetting bed: _____

Described any questions or comments child has had about sex: _____

At what age did temper tantrums begin? _____ Describe: _____

Who currently disciplines child/adolescent? _____ How? _____

Describe childhood fears and how they were handled: _____

Describe any sleep disturbances: _____

Describe any eating problems: _____

Has child/adolescent used drugs or alcohol? _____ Explain: _____

How many times has child/adolescent moved? _____ What ages? _____

Describe any history of neglect, physical abuse or sexual abuse: _____

List several significant events in child/adolescent's life: _____

_____

SYMPTOM CHECKLIST

Please check each symptom experienced within the past two months. Then circle the top five symptoms.

___ Depressed mood
___ Decrease motivation
___ Hopeless or helpless
___ Decreased energy
___ Irritable mood
___ Mood swings
___ Withdrawn
___ Increase crying
___ Suicidal thoughts
___ Suicidal attempt
___ Self-abusive behavior
___ Conduct problem
___ Harms others
___ Stealing
___ Poor social skills
___ Obsessive thoughts
___ Compulsive behavior
___ Nightmares
___ Anxiety/Worry
___ Intense fear
___ Short attention span
___ Hyperactivity
___ Impulsive
___ Daydreaming
___ Indecisive
___ Memory problem
___ Temper outbursts
___ Insomnia
___ Lying
___ Hears voices
___ Sees things that are not there
___ Racing thoughts
___ Increased energy
___ Sexual problem
___ Stomach aches
___ Headaches
___ Conflicts with peers
___ Urination or bowel problems
___ Socially withdrawn
___ Fatigue
___ Pulls out hair
___ Change of appetite
___ Fire setting

SCHOOL

Circle your child's current grade placement: K 1 2 3 4 5 6 7 8 9 10 11 12 Other: _____

Describe current problems in school: _____

Explain when these problems began: _____

Circle *current* grades: A B C D F Circle grades from *last school year*: A B C D F

Describe any history of learning disabilities: _____

Describe any special program child involved with in school: _____

Has anyone ever said your child/adolescent is hyperactive or has attention problems? _____

Describe any grade failures or retentions:_____

HEALTH HISTORY (Please fill in completely, even if some things do not seem important)

Illnesses & Hospitalizations	Age	Length	Fever – Unconscious?	Treatment & Aftereffects

Accidents	Age	Unconscious?	Treatment & Aftereffects

List all **medications** child/teen now taking	Name of Dr. prescribing	Purpose of medication

Head injuries? ____ No ____ Yes Explain: _____

Seizures? _____ No _____ Yes Explain: _____

High Fevers _____ No _____ Yes Explain: _____

Describe any history of ear infections: _____

RELIGIOUS

Church affiliation: _____

Describe child's level of participation in religious activities: _____

THERAPY/GOALS

Describe any previous involvement with therapy or counseling: _____

What concerns you most about your child/adolescent at this point? _____

_____

Why are you <u>now</u> bringing your child/adolescent in for therapy (versus before or later)? _____

_____

Describe how each parent feels about child/adolescent receiving therapy: _____

ADDITIONAL COMMENTS: _____

_____

_____ _____ _____

Signature Relationship to child/adolescent Date