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CHILD/ADOLESCENT PERSONAL HISTORY

TO BE COMPLETED BY PARENT OR GUARDIAN. THE INFORMATION YOU PROVIDE TO US WILL BE VERY HELPFUL IN TREATING YOUR CHILD. PLEASE FILL OUT COMPLETELY. IF YOU HAVE ANY DIFFICULTY, COMPLETE AS MUCH AS POSSIBLE. YOUR CHILD'S THERAPIST WILL REVIEW THE FORM WITH YOU. THANK YOU!

Today's Date: ______________________ Your Name: ____

Child's Name:_______________________________DOB: _____________Current Age:__________________

How are you related to the child? ____

Address: ____Contact Phone__________________________

Email Address:____

Home Country:____________________________ Native Language: _________________________________

Child's Parents:		AGE
	____	________
Child's Siblings	____	__________

Child's birthplace ______________________________

Child was raised by: ____

Who lives in child's main household? ____

____

Whose idea was it to bring child to clinic? ____

What problems is your child having?____

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When has he/she been having these problems? _______________________________________

Why do you think your child is having problems?_____________________________________

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Describe how child's problems affect you, other family members, others:_________________

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What would you or referring person like to see done for your child? ____________________

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When and where has your child been evaluated or counseled before? _____________________

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Reason: ____

Has child ever threatened/attempted to HARM self or others?___________________________

Explain: ____

Have child's parents or any close relatives ever been in counseling at a clinic or been hospitalized for depression, hearing voices, alcohol or drug problems, suicide attempts, etc? Please explain who, where, when:

Who? _______________ When? ______________ Where? ________________ Why? __________________

Who? _______________ When? ______________ Where? ________________ Why? __________________

Who? _______________ When? ______________ Where? ________________ Why? __________________

How is child's PHYSICAL HEALTH? ____

Has child had serious illnesses, injuries, surgeries, hospitalizations? ______________________________

Explain: ____

Child's Physician: ____ Phone: ____________________

Office Address: ____ Phone: ____________________

Date child last saw physician: ______________ Reason:_______________________________________

Results of Doctor visit:____

Immunizations up-to-date: ____

Medications child is on: ____

Child's Height: _________________ Weight: ______________ Appetite: __________________________

Describe any recent weight gain/loss:____

Does child over-eat? __________ Refuse food? _________ Purge? ______________________________

Any food or medication allergies? ____

Child's usual energy/activity level: ____

DEVELOPMENTAL HISTORY:

Was your pregnancy desired? __________ Length of term: ___________________________________

Problems during pregnancy (include alcohol/drug usage by mother):_________________________________

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Complications during delivery: ____

Explain if mother/child separated after birth: ____

____

Other parent/child separations:____

Describe child as an infant/toddler (cheerful, fussy, cuddly, withdrawn): ______________________________

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Age child first sat up: ________ took steps: ________ spoke words: ______________________________
Age first spoke in sentences: _________ weaned: _________ fed him/herself: _________________________
Age toilet-trained during day: ________ night: _________ problem now? ____________________________
Age dressed self: _________ tied shoe-laces: _________ rode 2-wheel bike: __________________________
Age his voice changed (adolescent males): __________ developed body hair: ________________________
Age 1st menstruation (adolescent female): __________ breast development: _________________________

SCHOOL: ____ Grade: ____________________

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Address: ______________________________ Phone: ______________

Teacher: ______________________________ Counselor: ______________

In special classes?______________________ Since what grade? ______________

Learning disabilities? ______________________________

Has child repeated any grades? __________ Which grades?______________________

Describe attendance:______________________________

Describe effort/attitude toward school: ______________________________

Describe academic performance: ______________________________

Describe behavior in school:______________________________

When did school performance/behavior change?______________________________

Why do you think it changed? ______________________________

Education of each parent/guardian: ______________________________

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Client Name: ______________________

Employment/training/work hours of each parent/guardian:

You: ______________________________

Spouse/partner: ______________________________

<u>ETHNIC/CULTURAL</u> background of child: ______________________________

<u>RELIGIOUS/SPIRITUAL</u> background: ______________________________

<u>LEGAL</u> problems of child (past and present): ______________________________

____

<u>PARENT/CHILD RELATIONSHIP</u>:

How do you and spouse/partner show affection to child? ______________________________

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If one of child's biological parents is out of the home, describe his/her relationship with child: ______________

____

<u>RESPONSIBILITIES/RULES</u>:

____

____

How does child handle these? ______________________________

Has child threatened/attempted to run away or stayed out all night? ______________________

Explain: ____

What do you and your spouse/partner DO when your child misbehaves?

You: ____

Spouse/partner: ____

How do you and spouse/partner feel about using PHYSICAL DISCIPLINE?

You: ____

Spouse/partner: ____

Has family ever been involved with Protective Services? ______________________

When? ______________ Reason: ______________________________

Describe any BEHAVIOR of yourself, partner, or other adults in the home (drinking, drugs, verbal or physical conflict, suicide attempts, etc.) that may have affected your child: ______________________

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Describe any EVENTS--family illness, death, separation, divorce, move to a different neighborhood or school, change in family finances, etc.-- that may have affected your child: ______________________

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PLEASE REVIEW THE FOLLOWING LIST AND CIRCLE THE NUMBERS THAT YOU FEEL FIT YOUR CHILD. THEN WRITE THOSE NUMBERS BELOW AND BRIEFLY EXPLAIN:

1. Speech difficulties
2. Nervous habits/behavior
3. Frequent headaches
4. Frequent stomach-aches
5. Difficulty sleeping
6. Lacks guilt/remorse
7. Difficulty making friends
8. Difficulty keeping friends
9. Little interest in friends
10. Little interest in activities
11. Disrespectful/argumentative
12. Doesn't complete schoolwork
13. Acts before thinking
14. Short attention-span
16. Overactive
17. Underactive
18. Sucks thumb
19. Bangs head
20. Grinds teeth
21. Nightmares
22. Seems angry
23. Hurts animals
24. Sets fires
25. Steals
26. Lies a lot
27. Too serious
28. Fights a lot
29. Clowns a lot
31. Temper tantrums
32. In own world
33. Afraid/fearful
34. Accident-prone
35. Seems insecure
36. Sad/depressed
37. Worries a lot
38. Cries frequently
39. Mentally slow
40. Interested in sex
41. Looks "high" often
42. Separation problems
43. Imaginary friends
44. Ignores rules

15. Unable to sit still	30. Acts spoiled	45. Defies authority

#_____ Explain: ____

#_____ Explain: ____

#_____ Explain: ____

#_____ Explain: ____

#_____ Explain: ____

#_____ Explain: ____

#_____ Explain: ____

INTERESTS/ACTIVITIES (Please circle or check):

Watch television	Play sports	Sew	Skate	Baby-sitting
Be with friends	Ride Bicycle	Draw	Write	Imaginary play
Play video games	Roller blade	Read	Scouts	Action figures
Listen to music	Build things	Sing	School	Power Rangers
Talk on phone	Collect things	Dance	Crafts	Dolls

Other: ____

Activities/Interests child no longer enjoys: ______________________________

For individuals living abroad or families with multiple school placements, please list the specific dates and details of the changes over time:

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