Personal History for Children and Adolescents (<18)

Client's name: _____Date of Birth:_____Today's Date: _____

Child's current age: _____ Gender:_____
(years/months)

Form completed by:_____relationship to 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:

_____
_____
_____

HOME AND FAMILY INFORMATION

With whom does the child live at this time?_____
Are parent's divorced/separated/widowed/cohabiting? _____
Who has legal custody? _____
Are/were the child's birth parents married? ____Yes ____ No Year_____
Nature of relationship of birth parents at the time of child's conception and birth:

_____
_____
_____
_____

Client's Parent #1 Information

Name: _____Age: ____ Occupation: _____FT PT
Where employed: _____ Position:_____
Work phone: _____Cell:_____
Education: _____
Is the child currently living with this parent? ____FT ____ PT _____Not at all
Is this parent the following: ___ Birth parent ____ Step-parent ____Adoptive parent ____Foster Parent
Other (specify): _____
Please indicate anything notable, unusual or stressful about the child's relationship with this parent:

_____
_____
_____

How is the child disciplined by this parent? _____
For what reasons is the child disciplined by this parent? _____

Client's Parent #2 Information

Name: _____Age: ____ Occupation: _____FT PT

Where employed: _____ Position:_____

Work phone: _____Cell:_____

Education: _____

Is the child currently living with this parent? ____FT ____ PT _____Not at all

Is this parent the following: ___ Birth parent ____ Step-parent ____Adoptive parent ____Foster Parent

Other (specify): _____

Please indicate anything notable, unusual or stressful about the child's relationship with this parent:

_____

_____

_____

How is the child disciplined by this parent? _____

For what reasons is the child disciplined by this parent? _____

Client's Parent #3 Information

Name: _____Age: ____ Occupation: _____FT PT

Where employed: _____ Position:_____

Work phone: _____Cell:_____

Education: _____

Is the child currently living with this parent? ____FT ____ PT _____Not at all

Is this parent the following: ___ Birth parent ____ Step-parent ____Adoptive parent ____Foster Parent

Other (specify): _____

Please indicate anything notable, unusual or stressful about the child's relationship with this parent:

_____

_____

_____

How is the child disciplined by this parent? _____

For what reasons is the child disciplined by this parent? _____

Client's Parent #4 Information

Name: _____Age: ____ Occupation: _____FT PT

Where employed: _____ Position:_____

Work phone: _____Cell:_____

Education: _____

Is the child currently living with this parent? ____FT ____ PT _____Not at all

Is this parent the following: ___ Birth parent ____ Step-parent ____Adoptive parent ____Foster Parent

Other (specify): _____

Please indicate anything notable, unusual or stressful about the child's relationship with this parent:

_____

_____

_____

How is the child disciplined by this parent? _____

For what reasons is the child disciplined by this parent? _____

Who handles responsibility for your child in the following areas?

School: _____
Health care :_____
Problem behavior: _____
Extracurricular activities: _____

List co-parenting concerns and issues regarding these responsibilities:

_____
_____
_____
_____
_____

Child's Siblings and Others Who Live in the Household (indicate parent/head of 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, parent's significant other)**	
_____	____	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

Comments: _____
_____

Child's Siblings and Others Who Live in the Household (indicate parent/head of household:_____

Names of Siblings	Age	Gender	Living	Quality of relationship with the client
_____	____	F M	___ home ___ away	___ poor ___ average ___ good
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_____	____	F M	___ home ___ away	___ poor ___ average ___good
_____	____	F M	___ home ___ away	___ poor ___ average ___ good
Others living inthe household			**(e.g., cousin, foster child, parent's significant other)**	
_____	____	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

Comments:

_____
_____

Describe how the child gets along with family members, the nature of the marital relationships; if divorce, the nature of the co-parenting relationship, family issues/concerns, etc. Please be as specific as you can.

Describe cultural, ethnic, spiritual or religious attributes, concerns or issues, or other influences that shape, describe, or define this child's family situation and how the child fits.

What are this child's and family's social supports outside of the immediate caregiving team?

Child's hobbies/interests:

Family hobbies/interests:

Describe child's level and choices of activity with regard to use of "screens," that is, television, movie watching, videogames, hand-held games, use of tablets, computers, cell/smart phones and texting, Skype, social media, etc., and how it is regulated by the caregivers.

EDUCATIONAL and SOCIAL

Age child began first grade: _____ Current school and grade level _____

Did child attend infant daycare? Y N Where? _____

Did child attend preschool? Y N Where? _____

Did child attend kindergarten? Y N Where? _____

Other schools attended _____

Type of Schools attended: __ Public __Private _____ Home schooled _____ Other (specify):
_____
_____
_____

In special education? Y N Describe: _____

In gifted program? Y N Describe: _____

Has child ever been held back in school? Y N What grade? _____
Describe circumstances:
_____
_____
_____

Favorite school subjects/activities
_____
_____

Least favorite school subjects/activities
_____
_____

Have there been any recent changes in the child's grades? Y N Describe:
_____
_____

Psychological/Educational Testing? Y N Describe when, reason for testing, person or entity who did the testing, results/outcome:
_____
_____
_____

What is this child's general pattern of results on standardized testing (ITBS, SAT, ACT, other achievement testing)
_____
_____
_____

Describe any changes or concerns regarding academic achievement. If there have been changes, indicate when those changes occurred and the nature of the changes.
_____
_____

Child's Feelings about School:

__ 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 Response to Authority at School:

_____
_____

Consequences given at school: Indicate nature of offense, frequency, patterns, child's response:

_____
_____

Child's Peer Relationships

__ Spontaneous ____ Follower ___ Leader ____ Difficulty making friends
__ Makes friends easily ____ Long-time friends___Shares easily ____ Bullying issues

Describe your child's pattern of interaction with peers, activities shared, problems:

_____
_____
_____
_____
_____

Extracurricular Activities: Describe activity, level of participation, level of interest by child, frequency, duration, achievement/response (i.e. music, sports, theater, groups, part time job)

_____
_____
_____
_____
_____
_____

Client Name:_____

FAMILY SOCIAL/DEVELOPMENTAL HISTORY

Parents/Siblings with Developmental Delays: Name family member, age of child's experience with same, and describe issue such as intellectual/emotional/physical disability, learning problems, etc). _____

Substance Use: Name family member, substance, pattern of use, describe child's exposure to situation.

Physical and Mental Illness: Name family member, diagnosis, duration of illness, treatment including medications

Suicide or Suicide Attempts: Name family member, dates, methods, child's exposure and relationship, attendance at funeral/wake, etc., other significant details.

Witness/exposure to interpersonal violence or other violent events. Please describe:

Legal concerns. Describe current and significant past legal issues, outcomes, current concerns, including arrests, convictions, jail time served:

_____
_____
_____
_____
_____
_____
_____
_____

Are there firearms or other weapons in any home where the child resides? Y N
Please provide details of types, security, training, regular use, by whom, etc.

_____
_____
_____
_____
_____
_____

Other concerns not listed above:

_____
_____
_____
_____
_____

DEVELOPMENTAL HISTORY SPECIFIC TO IDENTIFIED CHILD/ADOLESCENT

Pregnancy

Duration:_____
Smoking during preg Y N Amt daily_____
Alcohol Use during preg Y N Amt/Type_____
_____
Use of drugs Y N Details_____
_____
Prescribed meds Y N Details:_____
Complications:_____

Delivery

Labor: ___Spontaneous ___Induced
Duration:_____
Type of Delivery: ___Vaginal ____C-section___Breech
Premature: Y N
Birth weight: _____ Length_____
Infant Days in Hospital_____
APGARS:_____

_____
_____

Describe your child's milestones (ages accomplished, problems, concerns):
Motor Skills (rolling over, crawling, creeping, walking, running).

_____
_____
_____
_____

Client Name:_____

Language development

_____
_____
_____
_____
_____

Attachment Development with Caregivers/Family Members:

_____
_____
_____
_____

Toilet Training **Age achieved bowl control: _____** **Age achieved urinary control _____**

Describe ongoing concerns:

_____
_____
_____
_____
_____

Adolescents:

Age for following developments (fill in where applicable)

Began puberty: _____ **Began menstruation: _____ regular? Y N**

Voice change: _____ **Sexually active:_____Birth Cntr Method_____**

Describe any issues or concerns below:

_____
_____
_____
_____
_____

Do you suspect substance use? Y N

Describe:

_____
_____
_____
_____

Do you suspect child's involvement in illegal activity or gang involvement? Y N

Describe:

_____
_____
_____
_____

Other developmental concerns

_____
_____

CHILD'S MEDICAL HISTORY: Check if child has ever experienced the following:

___ Abortion	**____ Hayfever**	**____ Pneumonia**
___ Asthma	**____ Heart trouble**	**____ Polio**
___ Blackouts	**____ Hepatitis**	**____ Pregnancy**
___ Bronchitis	**____ Hives**	**____ Rheumatic Fever**
___ Cerebral Palsy	**____ Influenza**	**____ Scarlet Fever**
___ Chicken Pox	**____ Lead poisoning**	**____ Seizures**
___ Congenital problems	**____ Measles**	**____ Severe colds**
___ Croup	**____ Meningitis**	**____ Severe head injury**
___ Diabetes	**____ Miscarriage**	**____ Sexually transmitted disease**
___ Diphtheria	**____ Multiple sclerosis**	**____ Thyroid disorders**
___ Dizziness	**____ Mumps**	**____ Vision problems**
___ Ear aches	**____ Muscular Dystrophy**	**____ Wearing glasses**
___ Ear infections	**____ Nose bleeds**	**____ Wearing hearing aids**
___ Eczema	**____ Other skin rashes**	**____ Whooping Cough**
___ Encephalitis	**____ Paralysis**	**____ Other (describe)_____**
___ Fevers	**____ Pleurisy**	

Describe your child's general health:

_____
_____
_____
_____
_____

Serious Illnesses:

_____
_____
_____
_____

Head Injuries? Y N ____ Without loss of consciousness _____With loss of consciousness
Duration_____
Describe circumstances:

_____
_____
_____
_____

History of problems with Eating/Weight/Failure to Thirve or other eating disorder concerns? Y N
Describe:_____
_____
_____
_____
_____
_____

History of sleep problems/nightmares/night terrors? Y N
Describe:_____
_____
_____
_____
_____
_____

History of broken bones/injuries/accidents? Y N
Describe, including dates, circumstances, treatment and outcomes

_____
_____
_____
_____
_____

Surgeries/Hospitalizations
Describe, with dates, procedures, outcomes:
_____
_____
_____
_____
_____

Convulsions/Seizures? Y N ____with fever _____ without fever
Describe treatments/details:
_____
_____
_____

Allergies? Y N
Describe type, symptoms, frequency, duration, treatments:
_____
_____
_____

Immunications up to date? Y N Date of last medical checkup _____ (month/year)
If not immunized, indicate rationale:
_____
_____

List name and contact information of your child's primary care physician and other health care providers your child sees:
_____
_____
_____
_____
_____
_____

Medications: Please list prescription, over-the-counter, and supplements used:

Name of medication dose frequency compliant (Y/N) reason for taking prescriber

If prescribed and not compliant currently, please explain:

TRAUMA and ABUSE HISTORY

Physical	**Y**	**N**	**Age____**	**By Whom:_____**
Sexual	**Y**	**N**	**Age____**	**By Whom:_____**
Emotional/ Verbal	**Y**	**N**	**Age____**	**By Whom:_____**
Abandonment	**Y**	**N**	**Age____**	**By Whom:_____**
Neglect	**Y**	**N**	**Age____**	**By Whom:_____**
Denial of Critical Care	**Y**	**N**	**Age____**	**By Whom:_____**

Witness to Abuse? _____Physical _____Sexual ____ Other (describe)_____
Age of child _____ By Whom:_____

Provide details regarding trauma/abuse questions above. (was it reported, is there DHS involvement, treatment plan, name of worker(s) involved; legal issues, etc)_____

Other Trauma/Grief/Loss/Medical Concerns (describe dates, circumstances, loss, reaction, current concerns) (deaths, moving, fire, witness to disaster, auto accident, seriously ill loved one or friend, including medical or mental illness, loss of pet, significant financial change in the family)

CURRENT BEHAVIORAL AND EMOTIONAL DESCRIPTORS

Please check below what is typical for your child:

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

Please list any other concern or attribute not otherwise mentioned:

_____
_____
_____
_____
_____
_____
_____

Client Name:_____

BEHAVIORAL HEALTH TREATMENT

Information about child/adolescent (past and present):

	Yes	No	When	Who/Where	Reaction or overall experience
Counseling/Psychiatric Treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Psych Hospitalizations	___	___	_____	_____	_____

Any additional information that you believe would assist in understanding your child/adolescent?

_____

_____

_____

Any additional information that would assist 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 a danger to self or others at this time? Y N Explain:_____

_____

_____

_____

Do you believe the child is experiencing psychotic symptoms (hallucinations, break with understanding of reality, significant obsessions or compulsions preventing reasonable daily functioning, etc) Y N Explain:

_____

_____

_____

_____

_____

Signed:_____ **Date:**_____

Relationship to child/adolescent:_____