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Personal History – Children and Adolescents <13

Please provide the following information and answer the questions below. Bring the form to your first session. Information you provide here is protected as confidential information.

Client Information

Name: **Date:**

Address: ______________________________

Birth Date: ______________ **Age:** **Gender:** ☐ Male ☐ Female

Form completed by (if other than client ______________________________
Name Relationship

Home Phone: ______________ May I leave a message? ☐ Yes ☐ No

Cell Phone: ______________ May I leave a message ☐ Yes ☐ No

Email*: ______________ May I email you? ☐ Yes ☐ No

*Please note: Email correspondence is not considered a confidential form of communication.

Emergency Contact: ______________________________
Name Relationship to you

Emergency Contact Phone Number: ______________________________

Referred by (if any): ______________________________

If you need more space for any of the following questions please use the back of the sheet.

Primary reason (s) for seeking services:

____

____

____

What are your goals for your child's/teen's therapy?

____

____

What family involvement would you like to see?

____

____

Family History

Parents:

With whom does the child/teen live at this time? ______________________________

Are parents: ☐ Never Married ☐ Domestic Partners ☐ Married ☐ Separated

☐ Divorced ☐ Widowed

If divorced or separated, who has legal custody? ______________________________

If divorced, has either parent remarried? ☐ Yes ☐ No

Mother Remarried ☐ Date: ____________ Spouse's Name: ____________________

Father Remarried ☐ Date: ____________ Spouse's Name: ____________________

Client's Mother

Name: ______________________ Age: ______ Occupation : ____________________

Where Employed ______________________ Work Phone ____________________

Mother's Education

Does child/teen current live with mother? ☐ Yes ☐ No

☐ Natural Parent ☐ Step Parent ☐ Adoptive Parent

☐ Other (Specify): ____

Anything notable or stressful about child's/teen's relationship with mother?

____

____

Client's Father

Name: ______________________ Age: ______ Occupation : ______________________

Where Employed ______________________ Work Phone ______________________

Father's Education ______________________

Does child/teen current live with father? ☐ Yes ☐ No

☐ Natural Parent ☐ Step Parent ☐ Adoptive Parent

☐ Other (Specify): ______________________

Anything notable or stressful about child's/teen's relationship with father?

____

____

Siblings

Name	Age	Gender	Lives	Relationship Quality
		☐ F ☐ M	☐ Home ☐ Away	☐ Poor ☐ Avg ☐ Good
		☐ F ☐ M	☐ Home ☐ Away	☐ Poor ☐ Avg ☐ Good
		☐ F ☐ M	☐ Home ☐ Away	☐ Poor ☐ Avg ☐ Good
		☐ F ☐ M	☐ Home ☐ Away	☐ Poor ☐ Avg ☐ Good

Others Living in Household

Name	Age	Gender	Relationship	Relationship Quality
		☐ F ☐ M		☐ Poor ☐ Avg ☐ Good
		☐ F ☐ M		☐ Poor ☐ Avg ☐ Good
		☐ F ☐ M		☐ Poor ☐ Avg ☐ Good
		☐ F ☐ M		☐ Poor ☐ Avg ☐ Good

Who handles responsibilities for your child/teen in the following areas:

School ☐ Mother ☐ Father ☐ Shared ☐ Other: ______________________

Health ☐ Mother ☐ Father ☐ Shared ☐ Other: ______________________

Problem Behavior ☐ Mother ☐ Father ☐ Shared ☐ Other: ______________________

Family Mental Health History

Is there a family history of any of the following? If yes, please indicate the family member's relationship to the client in the space provided.

Example:

Issue	Response	Relationship to Client
Anxiety	X Yes ☐ No	Maternal Grandmother and Mother

Issue	Response	Relationship to Client
ADHD	☐ Yes ☐ No	
Alcohol/Substance Abuse	☐ Yes ☐ No	
Anxiety	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Domestic Violence	☐ Yes ☐ No	
Eating Disorders	☐ Yes ☐ No	
Obsessive Compulsive Behavior	☐ Yes ☐ No	
Schizophrenia	☐ Yes ☐ No	
Suicide Attempts	☐ Yes ☐ No	

Early Development History

Any problems with child during pregnancy? ☐ Yes ☐ No

If **yes**, please explain:

Was pregnancy planned? ☐ Yes ☐ No

Mother's age at birth Father's age at birth

Type of delivery: ☐ Vaginal ☐ Cesarean-Section

Did mother smoke while pregnant? ☐ Yes ☐ No If yes, how much?

Did mother use drugs or alcohol? ☐ Yes ☐ No If yes, type/amount

While pregnant did mother have any medical or emotional difficulties? ☐ Yes ☐ No

If yes, please explain ______________________________

Any problems with child's birth or immediately after?? ☐ Yes ☐ No

If yes, please explain ______________________________

Please describe your child before the age of 2 (i.e., calm, active, difficult, fearful, sad, happy, etc.

____

____

Was it an easy or difficult attachment? ______________________________

Infancy/Toddlerhood

☐ 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

Please indicate the approximate ages when the following behaviors took place:

Sat alone	________	Dressed self	________
Took 1st steps	________	Tied shoelaces	________
Spoke words	________	Rode 2-wheeled bike	________
Spoke sentences	________	Toilet trained	________
Weaned	________	Dry during day	________
Fed self	________	Dry during night	________
Slept through night	________	Playing with others	________
Reading	________	Writing	________
Counting	________		

If needed, please explain any of the above: ______________________________

____

Compared with others in the family, the child's/teen's development was:

☐ Slow ☐ Average ☐ Fast

Age for following developments (if applicable):

Began puberty ______________ Menstruation ______________

Voice change ______________ Injuries/Hospitalized ______________

Education

Grade in School ______________________

School of Attendance ______________________

Type of school ☐ Public ☐ Private ☐ Home-schooled

What subjects does your child/teen enjoy in school? ______________________

What subjects does your child/teen enjoy in school ______________________

What grades does your child/teen usually receive in school

Does your child receive Special Education Services? ☐ Yes ☐ No

If yes, please explain ______________________

____

Check the descriptions that specifically relate to your child/teen:

Feelings about school work:

☐ Anxious	☐ Passive	☐ Enthusiastic	☐ Fearful
☐ Eager	☐ No Expression	☐ Bored	☐ Rebellious
☐ Other			

____

Approach to school work:

☐ Organized	☐ Industrious	☐ Responsible	☐ Interested
☐ Self-directed	☐ No Initiative	☐ Refuses	☐ Does only what's expected
☐ Sloppy	☐ Disorganized	☐ Cooperative	☐ Doesn't do assignments

Performance in school (Parent's opinion):

☐ Satisfactory ☐ Responsible ☐ Underachiever ☐ Overachiever

☐ Other ______________________________

Peer relationships:

☐ Spontaneous ☐ Makes friends easily ☐ Has long time friends ☐ Shares easily

☐ Difficulty making friends ☐ Follower ☐ Leader

☐ Other ______________________________

How many friends does your child/teen have at school? ______________

How much time do they play/hang out per week? ______________

How many friends does your child/teen have at home/through other activities? ______________

How much time do they play/hang out per week? ______________

Medical/Physical History

Pediatrician's Name ______________________________

Date of child's/teen's last medical exam ______________________________

Does your child wear glasses? ☐ Yes ☐ No

Has your child ever been hospitalized? ☐ Yes ☐ No

If yes, please explain ______________________________

Has your child/teen ever had a fever over 104 degrees? ☐ Yes ☐ No

If yes, please explain ______________________________

Has your child/teen ever had any accidents or serious injuries? ☐ Yes ☐ No

If yes, please explain ______________________________

Does your child/teen have asthma/allergies? ☐ Yes ☐ No

If yes, please explain ______________________________

Any other health concerns?

____

Describe your child's/teen's eating habits:

Meal	# Times/Week	Typical Foods Eaten	Amount typically Eaten
Breakfast	____ /week	____________	☐ Doesn't eat ☐ Low ☐ Med ☐ High
Lunch	____ /week	____________	☐ Doesn't eat ☐ Low ☐ Med ☐ High
Dinner	____ /week	____________	☐ Doesn't eat ☐ Low ☐ Med ☐ High
Snacks	____ /week	____________	☐ Doesn't eat ☐ Low ☐ Med ☐ High

Currently prescribed medications:

Dose	Dates	Purpose	Side effects

Over the counter medications currently taken:

Dose	Dates	Purpose	Side effects

Does your child/teen use or have any issues with alcohol or drugs? ☐ Yes ☐ No

If yes, please explain ____

Does your child/teen receive any other counseling? ☐ Yes ☐ No

If yes, with whom? ____

Behavioral/Emotional

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

- ☐ Affectionate
- ☐ Aggressive
- ☐ Angry
- ☐ Avoids adults
- ☐ Bedwetting
- ☐ Blinking/jerking
- ☐ Bizarre behavior
- ☐ Bullies, threatens
- ☐ Careless, reckless
- ☐ Chest pains
- ☐ Clumsy
- ☐ Confident
- ☐ Cooperative
- ☐ Cyber addiction
- ☐ Defiant
- ☐ Depressed
- ☐ Destructive
- ☐ Difficulty speaking
- ☐ Dizziness
- ☐ Eating issues
- ☐ Enthusiastic
- ☐ Expects failure
- ☐ Fatigue
- ☐ Fearful
- ☐ Frequent injuries
- ☐ Frustrated easily
- ☐ Generous
- ☐ Hallucinations
- ☐ Head-banging
- ☐ Hopelessness
- ☐ Hurts animals
- ☐ Imaginary friends
- ☐ Impulsive
- ☐ Irritable
- ☐ Lazy
- ☐ Learning problems
- ☐ Lies frequently
- ☐ Listens to reason
- ☐ Loner
- ☐ Low self-esteem
- ☐ Messy
- ☐ Nightmares
- ☐ Obedient
- ☐ Often sick
- ☐ Oppositional
- ☐ Overweight
- ☐ Panic attacks
- ☐ Phobias
- ☐ Psychiatric problems
- ☐ Quarrels
- ☐ Sad
- ☐ Selfish
- ☐ Separation anxiety
- ☐ Sets fires
- ☐ Sexual acting out
- ☐ Shares
- ☐ Short attention span
- ☐ Shy, timid
- ☐ Sleeping problems
- ☐ Slow moving
- ☐ Soiling
- ☐ Speech problems
- ☐ Steals
- ☐ Stomach aches
- ☐ Suicidal threats
- ☐ Suicide attempts
- ☐ Talks back
- ☐ Teeth grinding
- ☐ Thumb sucking
- ☐ Tics or twitching
- ☐ Unsafe behaviors
- ☐ Unusual thinking
- ☐ Weight loss
- ☐ Withdrawn
- ☐ Worries Excessively

Please describe any of the above or any other concerns. Use the back of the page if more space is needed

Was there a clear time when behaviors became worse? ☐ Yes ☐ No

If yes, please describe

How often does the behavior(s) occur?

How are problems usually handled?

Leisure/Recreational

Describe hobbies or special interests your child might have (art, reading, crafts, fitness, sports, camping, dance, school activities, Scouts etc.)

What are the family's favorite activities?

How does your child/teen spend unstructured time??

Additional Information

What major stressors have occurred in your child's lifetime? (i.e., death, illness, divorce, domestic violence, abuse, addiction, moving) ______________________________

List your child's/teen's strengths ______________________________

List the three biggest stressors in your child's/teen's life currently ______________________________

Any additional information about your child/teen that you would like to share/feel is relevant?