Rum River Counseling

PERSONAL HISTORY – CHILDREN & ADOLESCENTS

Client's name: _____ Date: ___/___/_____

Gender: _____ Date of birth: ___/___/___ Age: _____ Grade in school: _____

Form completed by (if someone other than client): _____

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

Phone (home): _____ (work): _____ Ext: _____

Emergency contact name:_____Phone: _____

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: _____

Please complete the following section for each Parent

Parent Name: _____ Age: ____ Occupation: _____

Where employed: _____ ___FT __ PT Work phone: _____

Parent's education: _____

Is the child currently living with this parent? _____ 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 this parent?

____ Yes __ No If Yes, please explain: _____

_____

How is the child disciplined by this parent? _____

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

Parent Name: _____ Age: ____ Occupation: _____

Where employed: _____ ___FT __ PT Work phone: _____

Parent's education: _____

Is the child currently living with this parent? _____ 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 this parent?

____ Yes __ No If Yes, please explain: _____

_____

How is the child disciplined by this parent? _____

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

Client's Siblings and Others Who Live in the 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)	
_____	____	____F ____M	_____	___ poor ___ average ___ good
_____	____	____F ____M	_____	___ poor ___ average ___ good
_____	____	____F ____M	_____	___ poor ___ average ___ good
_____	____	____F ____M	_____	___ poor ___ average ___ 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:

____ Allergies	____ Deafness	____ Muscular Dystrophy
____ Anemia	____ Diabetes	____ Nervousness
____ Asthma	____ Glandular problems	____ Perceptual motor disorder
____ Bleeding tendency	____ Heart diseases	____ Mental Retardation
____ Blindness	____ High blood pressure	____ Seizures
____ Cancer	____ Kidney disease	____ Spinal Bifida
____ Cerebral Palsy	____ Mental illness	____ Suicide
____ Cleft lips	____ Migraines	____ Other (specify): _____
____ Cleft palate	____ Multiple sclerosis	_____

Comments re: Family Health: _____

_____

Childhood/Adolescent History

Pregnancy/Birth

Was the pregnancy with child planned? ___ Yes ____ No Length of pregnancy: _____

Mother's age at child's birth: _____ Other Parent/Father's age at child's birth: _____

Child was number ___ of _____ total children.

While pregnant did the mother smoke? ___ Yes __ No If Yes, what amount: _____

Did the mother use drugs of 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: _____

Describe any physical or emotional complications with the delivery: _____

_____

Describe any complications for the mother or the baby after the birth: _____

_____

Infancy/Toddlerhood Check all which apply:

____ 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

Developmental History Please note the approximate 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 occurrences (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.)

_____

_____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? ___ Yes ____ No

If Yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious

How important to your child are spiritual matters? ___ Not __ Little _____ Moderate __ Much

Is your child affiliated with a spiritual or religious group? _____ Yes _____ No

If Yes, describe: _____

Is your family affiliated with a spiritual or religious group? ___ Yes _____ No

If Yes, describe: _____

Would your child like your spiritual/religious beliefs incorporated into the counseling? _____ Yes ___ No

If Yes, describe: _____

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

____ Abortion	____ Hay-fever	____ 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	____ Whooping cough
____ Eczema	____ Other skin rashes	____ Other
____ Encephalitis	____ Paralysis	_____
____ Fevers	____ Pleurisy	

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

Please check if there have been any recent changes in the following:

____ Sleep patterns ____ Eating patterns ____ Behavior ____ Energy level

____ Physical activity level ____ General disposition ____ Weight ____ Nervousness/tension

Describe changes in areas in which you checked above: _____

_____

Most recent examinations	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last vision exam			

Last hearing exam _____ _____ _____

Most recent surgery _____ _____ _____
Other surgery _____ _____ _____
Upcoming surgery _____ _____ _____

Family history of medical problems: _____

Medications

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Allergic to any medications or drugs? ___ Yes ___ No
If Yes, describe: _____

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: _____

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? ___ Yes __ No
If Yes, describe & complete information below: _____

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol								
Barbiturates								
Valium/Librium								
Cocaine/Crack								
Heroin/Opiates								
Marijuana								

PCP/LSD/Mescaline								
Inhalants								
Caffeine								
Nicotine								
Over the counter								
Prescription drugs								
Other drugs								

Substance of preference

1. _____ 3. _____
2. _____ 4. _____

Substance Abuse Questions <u>to be answered by Child/Adolescent</u>

Describe when and where you typically use substances: _____

Describe any changes in your use patterns: _____

Describe how your use has affected family or friends (include their perceptions of your use):

Reason(s) for use:

___ Addicted ___ Build confidence ___ Escape ___ Self-medication

___ Socialization ___ Taste ___ Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

___ Yes ___ No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ___ Yes ___ No

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

Does your body temperature change when you drink? _____ Yes _____ No

If Yes, describe: _____

Have drugs or alcohol created a problem for your job or school? _____ Yes ____ No

If Yes, describe: _____

Counseling/Prior Treatment History

*<u>Information about **child/adolescent** (past and present):</u>* _____

	Yes	No	When	Where	Child/Adolescent's reaction to overall experience
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____

Hospitalizations	____	____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	_____	_____	_____

*Information about **family/significant others** (past and present):*

	Yes	No	When	Where	Child/Adolescent's reaction to overall experience
Counseling/Psychiatric treatment	____	____	_____	_____	_____
Suicidal thoughts/attempts	____	____	_____	_____	_____
Drug/alcohol treatment	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	_____	_____	_____

Behavioral/Emotional

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

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

Please describe any of the above (or other) concerns: _____

_____

How are your child's problematic 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?

_____

_____

_____

Any additional information that would assist us 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 suicidal at this time? _____ Yes _____ No

If Yes, explain: _____

_____

For Staff Use

Therapist's comments: _____

_____

_____

Therapist's signature/credentials: _____ Date: _____/____/_____

Supervisor's comments: _____

_____

_____ Physical exam: _____ Required ____ Not required

Supervisor's signature/credentials: _____ Date: _____/____/_____

(Certifies case assignment, level of care and need for exam)