

Children and Adolescents History

Client's name: _____ Date: _____
Gender: ___ F ___ M Date of birth: _____ Age: _____
Grade in school: _____
Form completed by (if someone other than client): _____
Address: _____ City: _____ State: _____ Zip: _____
Phone (home): _____ Work _____ Ext: _____
Primary Reason for seeking counseling at this time:

Family History

Parents

With whom does the child live at this time?

Are parents divorced, separated, or never married?

If yes, who has legal custody?

Is there any significant information about the parents' relationship or treatment toward the child that might be beneficial in counseling?

If yes, describe:

Have there been any other significant changes or events in your child's life? (Family, moving, fire, etc.) If yes, describe...

Mother's Name: _____ Age: _____ Occupation: _____

Employed: _____ Work phone: _____

Mother's education: _____

Is the child currently living with mother?

_____ Natural parent _____ Stepparent _____ Adoptive
parent _____ Foster home _____ other (specify): _____

Is there anything notable, unusual, or stressful about the child's relationship with the mother?

How does the mother discipline the child?

For what reasons is the child disciplined by the mother?

Client's Father

Name:

Age:

Occupation:

Employed

Work phone:

Father's education:

Is the child currently living with father? Yes.....No

**_____ Natural parent _____ Stepparent _____ Adoptive
parent _____ Foster home _____ other (specify):**

Is there anything notable, unusual, or stressful about the child's relationship with the father?

How does the father discipline the child?

For what reasons is the child disciplined by the father?

Client's Siblings and Others Who Live in the Household

Names of Siblings Age Gender Relationship with the client

Others living in the household Relationship (e.g., cousin, foster child)

Developmental History: Please notes the approximate age or any concerns, at which the following took place:

Sat alone: _____

Dressed self: _____

Took first steps: _____

Tied shoelaces: _____

Spoke words: _____

Rode two-wheeled bike: _____

Spoke sentences: _____

Toilet trained: _____

Fed self: _____

Dry during night: _____

Age for following developments (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.)

Health/Medical

Current Pediatrician

Address:

Phone Number:

Would you consider your Child to be Healthy? Any Medical Conditions?

Hospitalizations/Surgeries (date/reason)

Current prescribed medications Dose Purpose Side effects

Current over-the-counter meds Dose Purpose Side effects

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 by a psychologist? _____ **Yes** _____
_____ **No**

If yes, describe: _____

Peer Relationships _____

_____ **Spontaneous** _____ **Follower** _____ **Leader**

_____ **Difficulty making Friends**

_____ **Makes friends easily** _____ **Long-time friends** _____ **Shares**
easily

_____ **Other (describe):** _____

Employment/Vocational Training

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?

Current employer Position: Hours per week:

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
the past?

How often now?

How often in

What are the family's favorite activities?

What does the child/adolescent do with unstructured time?

Psychiatric/Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs?

YesNo

If Yes, describe...

Drug or Alcohol Treatment? Yes..No

Please explain...

Any previous counseling for child?

If yes, please provide dates, name of counselor, and response to treatment:

Any additional information that you believe would assist me 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? _____