Clovis Counseling

PERSONAL HISTORY

Children & Adolescents (<18)

Client Information

Child's Name: _____ Date: ___/___/___

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

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

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

Home Phone: _____ Work Phone: _____ Ext: _____

Primary reason(s) for seeking services:

☐ Anger management	☐ Anxiety	☐ Coping	☐ Depression
☐ Eating disorder	☐ Fear/phobias	☐ Concentration	☐ Sexual concerns
☐ Sleeping problems	☐ Addictive behaviors	☐ Alcohol/drugs	☐ Hyperactivity

☐ Other mental health concerns or behaviors (specify):

_____

_____

_____

How long have the above issues been experienced? _____

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

Family History

PARENTS

With whom does the child live at this time? _____

Are parents divorced or separated? _____

If Yes, who has legal custody? _____

Were the child's parents ever married? ☐ Yes ☐ No If so, when? _____

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: _____

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Family History (CONT.)

CHILD'S MOTHER

Name: _____ Age: _____ Occupation: _____ ☐ FT ☐ PT

Where employed: _____ Work phone: _____

Mother's education: _____

Is the child currently living with mother? ☐ 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 mother?

☐ Yes ☐ No If Yes, please explain :_____

_____

How is the child disciplined by the mother? _____

For what reasons is the child disciplined by the mother? _____

How are you the same or different as a parent, than your parents were with you? _____

_____

_____

CHILD'S FATHER

Name: _____ Age: _____ Occupation: _____ ☐ FT ☐ PT

Where 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?

☐ Yes ☐ No If Yes, please explain :_____

_____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

How are you the same or different as a parent, than your parents were with you? _____

_____

_____

CHILD'S SIBLINGS

NAME OF SIBLING	AGE	GENDER	LIVES AT HOME?	QUALITY OF RELATIONSHIP WITH THE CHILD
		☐ 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
		☐ F ☐ M	☐ home ☐ away	☐ poor ☐ average ☐ good

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Family History (CONT.)

OTHERS WHO LIVE IN THE HOUSE

OTHERS LIVING IN HOUSEHOLD	AGE	GENDER	RELATIONSHIP (E.G. COUSIN, FOSTER CHILD)	QUALITY OF RELATIONSHIP WITH THE CHILD
		☐ F ☐ M		☐ poor ☐ average ☐ good
		☐ F ☐ M		☐ poor ☐ average ☐ good
		☐ F ☐ M		☐ poor ☐ average ☐ good
		☐ F ☐ M		☐ poor ☐ average ☐ good
		☐ F ☐ M		☐ poor ☐ average ☐ good

Comments: _____

_____

_____

_____

Health History

FAMILY HEALTH HISTORY

Have any of the following occurred among the child's blood relatives? (parents, siblings, aunts, uncles, or grandparents) Check those which apply:

☐ Allergies
☐ Anemia
☐ Asthma
☐ Bleeding tendency
☐ Blindness
☐ Cancer
☐ Cerebral palsy
☐ Cleft lips
☐ Cleft palate
☐ Deafness
☐ Diabetes
☐ Glandular problems
☐ Heart diseases
☐ High blood pressure
☐ Kidney disease
☐ Mental illness
☐ Migraines
☐ Multiple sclerosis
☐ Muscular dystrophy
☐ Nervousness
☐ Perceptual motor disorder
☐ Mental retardation
☐ Seizures
☐ Spina bifida
☐ Suicide
☐ Other (specify): _____

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Health History (CONT.)

PREGNANCY/BIRTH

Has the child's mother had any occurrences of miscarriages or stillbirths? ☐ Yes ☐ No
If Yes, describe: _____
Was the pregnancy with child planned? ☐ Yes ☐ No Length of pregnancy: _____
Mother's age at child's birth: _____ Father's age at child's birth: _____
Child 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: _____
Length of labor: _____ Induced: ☐ Yes ☐ No Caesarean? ☐ Yes ☐ No
Baby's birth weight: _____ Baby's birth length: _____
Describe any physical or emotional complications with the delivery: _____
_____
Describe any complications for the mother or the baby after the birth: _____
_____
Length of hospitalization: Mother: _____ Baby :_____

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 age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____
Took 1st steps: _____ Tied shoelaces: _____
Spoke words: _____ Rode two-wheel 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

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Health History (CONT.)

DEVELOPMENTAL HISTORY (CONT.)

Injuries or hospitalizations: _____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

_____

_____

_____

Education

SCHOOL INFORMATION

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: _____

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): _____

Education (CONT.)

In the following sections, please check the descriptions that specifically relate to your child.

FEELINGS ABOUT SCHOOLWORK:

☐ Anxious ☐ Passive ☐ Enthusiastic ☐ Fearful
☐ Eager ☐ No expression ☐ Bored ☐ Rebellious
☐ Other (describe): _____

APPROACH TO SCHOOLWORK:

☐ 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 ☐ Longtime friends ☐ Shares easily
☐ Other (describe): _____

CHILD'S EMPLOYMENT HISTORY

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: _____

Education (CONT.)

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 History

MEDICAL CONDITIONS

Please check all that apply:

- ☐ Abortion
- ☐ Asthma
- ☐ Blackouts
- ☐ Bronchitis
- ☐ Cerebral palsy
- ☐ Chicken pox
- ☐ Congenital problems
- ☐ Croup
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Dizziness
- ☐ Earaches
- ☐ Ear infections
- ☐ Eczema
- ☐ Encephalitis
- ☐ Fevers
- ☐ Hay fever
- ☐ Heart trouble
- ☐ Hepatitis
- ☐ Hives
- ☐ Influenza
- ☐ Lead poisoning
- ☐ Measles
- ☐ Meningitis
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Muscular dystrophy
- ☐ Nosebleeds
- ☐ Other skin rashes
- ☐ Paralysis
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Pregnancy
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Seizures
- ☐ Severe colds
- ☐ Severe head injury
- ☐ Sexually transmitted disease
- ☐ Thyroid disorders
- ☐ Vision problems
- ☐ Wearing glasses
- ☐ Whooping cough
- ☐ Other _____

Medical History (CONT.)

MEDICAL CONDITIONS (CONT.)

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

NUTRITION

MEAL	HOW OFTEN (TIMES PER WEEK)	TYPICAL FOODS EATEN	TYPICAL AMOUNTS EATEN
Breakfast	_____ / week		☐None ☐Low ☐Med ☐High
Lunch	_____ / week		☐None ☐Low ☐Med ☐High
Dinner	_____ / week		☐None ☐Low ☐Med ☐High
Snacks	_____ / week		☐None ☐Low ☐Med ☐High

Comments: _____

_____

MOST RECENT EXAMINATIONS

TYPE OF EXAMINATION	DATE (MOST RECENT VISIT)	RESULTS
Physical examination		
Dental examination		
Vision examination		
Hearing examination		

Are the child/adolescent's immunizations up to date? ☐ Yes ☐ No Most recent: _____

Medical History (CONT.)

MEDICATIONS

CURRENT PRESCRIBED MEDICATIONS	DOSE	DATES	PURPOSE	SIDE EFFECTS

CURRENT OVER-THE-COUNTER MEDICATIONS	DOSE	DATES	PURPOSE	SIDE EFFECTS

CHEMICAL USE HISTORY

Does the child/adolescent use or have a problem with alcohol or drugs? ☐ Yes ☐ No

If Yes, describe: _____

COUNSELING/PRIOR TREATMENT HISTORY

EVENT	OCCURRED?	WHEN	WHERE	REACTION OR OVERALL EXPERIENCE
Counseling/ Psychiatric treatment	☐ Yes ☐ No			
Suicidal thoughts/attempts	☐ Yes ☐ No			
Drug/alcohol treatment	☐ Yes ☐ No			
Hospitalizations	☐ Yes ☐ No			

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Behavioral History

Please check any of the following that are 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
- ☐ Drug 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
- ☐ Overactive
- ☐ 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
- ☐ Stomachaches
- ☐ Suicidal threats
- ☐ Suicidal attempts
- ☐ Talks back
- ☐ Teeth grinding
- ☐ Thumb sucking
- ☐ Tics or twitching
- ☐ Unsafe behaviors
- ☐ Unusual thinking
- ☐ Weight loss
- ☐ Withdrawn
- ☐ Worries excessively
- ☐ Other: _____
  _____

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

_____

_____

How are problem behaviors generally handled? _____

_____

What are the family's favorite activities? _____

_____

Behavioral History (CONT.)

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 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 are the child's strengths? _____

_____

_____

What family involvement would you like to see in the therapy?_____

_____

FOR STAFF USE

Therapist's comments: _____

_____

_____

_____

_____

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