



## Child/Adolescent Personal History (Ages 17 & Under)

TO BE FILLED OUT BY THE PARENT OR GAURDIAN. PLEASE FILL OUT COMPLETELY. IF YOU HAVE DIFFICULTY WITH ANY OF THE QUESTIONS, YOUR CHILD'S THERAPIST WILL REVIEW TTHEM WITH YOU. THANK YOU!

CHILD'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

AGE: \_\_\_\_\_ DOB: \_\_\_\_\_ Person completing form for Client: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_ Contact phone number: \_\_\_\_\_

	FULL NAME	AGE	LIVING IN THE HOME?
MOTHER			Y/N
FATHER			Y/N
STEP MOTHER			Y/N SPECIFY LENGTH OF TIME IN HOME:
STEP FATHER			Y/N SPECIFY LENGTH OF TIME IN HOME:
BROTHERS & SISTERS (Included Step & Half)			Y/N
			Y/N
			Y/N
			Y/N
			Y/N
Others			Y/N SPECIFY LENGTH OF TIME IN HOME:
			Y/N SPECIFY LENGTH OF TIME IN HOME:

Who was the child was raised by? \_\_\_\_\_

**Problem:** Describe the problems that child is having (behaviors, feelings, attitudes, school performance, etc.)

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What is the child's main problem? \_\_\_\_\_

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How long has he/she been having these problems? \_\_\_\_\_

Why do you think the child is having these problems? \_\_\_\_\_

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Whose idea was it to have the child seek help? \_\_\_\_\_

What would you or they like to see done for the child? \_\_\_\_\_

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Describe how the child's problems affect you, other family members and others: \_\_\_\_\_

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**ETHNIC/CULTURAL BACKGROUND (CHILD):** \_\_\_\_\_

**RELIGIOUS/SPIRITUAL BACKGROUND (CHILD):** \_\_\_\_\_

**SEXUAL/GENDER ISSUES (Describe any sexual or gender concerns you have about child):** \_\_\_\_\_

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**SYMPTOMS: Circle all of the items that you believe fits this child**

- |                                  |                                 |                              |
|----------------------------------|---------------------------------|------------------------------|
| 1. Speech difficulties           | 22. Lies a lot                  | 42. Afraid/fearful           |
| 2. Nervous habits/behavior       | 23. Breaks curfew often         | 43. Seems insecure           |
| 3. Frequent headaches            | 24. Runs away                   | 44. Withdrawn                |
| 4. Frequent stomach-aches        | 25. Skips school                | 45. Shy                      |
| 5. Sleep disturbance             | 26. Doesn't complete schoolwork | 46. Sad/depressed            |
| 6. Difficulty making friends     | 27. Has problematic friends     | 47. Cries frequently         |
| 7. Difficulty keeping friends    | 28. Underactive                 | 48. Won't sleep in own bed   |
| 8. Little interest in friends    | 29. Overactive                  | 49. Seems to serious         |
| 9. Little interest in activities | 30. Acts before thinking        | 50. Secretive                |
| 10. Disrespectful                | 31. Short attention-span        | 51. Looks "high" often       |
| 11. Argumentative                | 32. Unable to sit still         | 52. Keeps to him/herself     |
| 12. Temper tantrums              | 33. Clowns a lot                | 53. Avoids family activities |
| 13. Ignores rules/chores         | 34. Accident-prone              | 54. In his/her own world     |
| 14. Defies authority             | 35. Sucks thumb                 | 55. Imaginary friends        |
| 15. Threatening behavior         | 36. Wets the bed                | 56. Unusual behavior         |
| 16. Throws/breaks things         | 37. Wets/soils clothes          | 57. Mentally slow            |
| 17. Gets in frequent fights      | 38. Bangs head                  | 58. Nightmares               |
| 18. Hurts animals                | 39. Grinds teeth                | 59. Acts spoiled             |
| 19. Sets fires                   | 40. Separation problems         | 60. Too interested in sex    |
| 20. Steals                       | 41. Worries a lot               | 61. Disorganized/messy       |

Please explain each item that you circled (You may also write on the back of this page): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has child ever expressed a wish that he or she were dead? \_\_\_\_ How recently? \_\_\_\_\_

Has child ever threatened or attempted to seriously ham self or others? \_\_\_\_\_

Please explain: \_\_\_\_\_

\_\_\_\_\_

**INTERESTS/ACTIVITIES (Check all that apply to child):**

- |                       |                   |           |              |                    |
|-----------------------|-------------------|-----------|--------------|--------------------|
| ___ Watch television  | ___ Play sports   | ___ Paint | ___ Skate    | ___ Baby sit       |
| ___ Movies/videos     | ___ Ride Bicycle  | ___ Draw  | ___ Write    | ___ Imaginary Play |
| ___ Play video games  | ___ Rollerblade   | ___ Read  | ___ Scouting | ___ Action Figures |
| ___ Listen to music   | ___ Build things  | ___ Sing  | ___ School   | ___ Dolls          |
| ___ Talk on the phone | ___ Collect thing | ___ Dance | ___ Crafts   | ___ Sew/knits      |

Other interest/activities: \_\_\_\_\_

Has child lost interest in activities that he/she normally enjoyed? \_\_\_\_\_

**FAMILY RELATIONSHIPS:**

How do you get along with child? \_\_\_\_\_

How does spouse/partner get along with child? \_\_\_\_\_

If one or both of child's parents are out of the home, describe each one's current relationship with child: \_\_\_\_\_

Father: \_\_\_\_\_ Mother: \_\_\_\_\_

How does child get along with brothers & sisters? \_\_\_\_\_

**EDUCATION:** Name of school: \_\_\_\_\_ Grade: \_\_\_\_\_

School Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Teacher: \_\_\_\_\_ Counselor: \_\_\_\_\_

Is child in any Special classes? \_\_\_\_\_ Since what grade? \_\_\_\_\_

Does child have any Learning Disabilities? \_\_\_\_\_

Has child repeated any grades? \_\_\_\_\_ Which ones? \_\_\_\_\_

Describe child's attendance: \_\_\_\_\_

Describe effort/attitude toward school: \_\_\_\_\_

Describe academic performance: \_\_\_\_\_

When did school behavior or academic performance change? \_\_\_\_\_

Education of each parent or guardian: \_\_\_\_\_

**EMPLOYMENT:** Does child work? \_\_\_\_\_ Where does child work? \_\_\_\_\_ Hours per week? \_\_\_\_\_

Employment/training/workhours of each parent or guardian:

You: \_\_\_\_\_

Your spouse/partner: \_\_\_\_\_

**PHYSICAL HEALTH:**

Child's Physician: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Date child last saw Physician: \_\_\_\_\_ Reason: \_\_\_\_\_

Results of Physician visit/tests: \_\_\_\_\_

Medications child is on: \_\_\_\_\_

Immunizations up to date? \_\_\_\_\_

Child's Heights: \_\_\_\_\_ Weight: \_\_\_\_\_ Appetite: \_\_\_\_\_ Recent weight gain? \_\_\_\_\_ Loss? \_\_\_\_\_

Does child over-eat? \_\_\_\_\_ Binge? \_\_\_\_\_ Purge? \_\_\_\_\_ Energy/activity level: \_\_\_\_\_

Food or medication allergies: \_\_\_\_\_

If child has had any serious illnesses, injuries, surgeries or medical hospitalizations, please explain:

\_\_\_\_\_

**Developmental History:**

Was your pregnancy desired? \_\_\_\_\_ Length of Term: \_\_\_\_\_

Problems/complications during pregnancy: \_\_\_\_\_

Did mother smoke, drink, use drugs during pregnancy? \_\_\_\_\_

Problems/complications during delivery: \_\_\_\_\_

Explain if mother and child were separated after birth: \_\_\_\_\_

Other mother/child separations: \_\_\_\_\_

Describe the child as an infant/toddler (happy, fussy, overactive, withdrawn, etc.): \_\_\_\_\_

Age child sat up: \_\_\_\_\_ Took steps: \_\_\_\_\_ Spoke words: \_\_\_\_\_ Spoke in sentences: \_\_\_\_\_

Age child was weaned: \_\_\_\_\_ Began feeding self: \_\_\_\_\_

Age that child was toilet-trained during the day: \_\_\_\_\_ During the night: \_\_\_\_\_ Problems now: \_\_\_\_\_

Age that child dressed self: \_\_\_\_\_ Age child tied own shoe-laces: \_\_\_\_\_ Age that child rode a 2-wheel bike: \_\_\_\_\_

**PREVIOUS MENTAL HEALTH OR ALCOHOL/SUBSTANCE ABUSE TREATMENT:**

**OUTPATIENT:** Has the child seen a therapist or counselor for personal or family problems or alcohol/drug treatment? \_\_\_\_\_

If yes, When \_\_\_\_\_ Where \_\_\_\_\_

Reason: \_\_\_\_\_

**INPATIENT:** Has the child seen a therapist or counselor for personal or family problems or alcohol/drug treatment? \_\_\_\_\_

If yes, When \_\_\_\_\_ Where \_\_\_\_\_

Reason: \_\_\_\_\_

Were any of the child's treatment experiences helpful? \_\_\_\_\_

What medications was child prescribed for emotional or behavioral problems? \_\_\_\_\_

Which of those medications were helpful? \_\_\_\_\_

List any of child's relatives (parents, grandparents, aunts, uncles, cousins, brothers, sisters) who have been hospitalized for personal or substance abuse problems (WHO, WHEN, WHERE): \_\_\_\_\_

Trauma History: (physical, sexual emotional abuse- other trauma) \_\_\_\_\_

**LEGAL HISTORY:** (Describe any legal problems that child has had in past or present):

\_\_\_\_\_  
\_\_\_\_\_

**Tobacco, caffeine and substance use:**

How many caffeinated beverages does child drink per day (coffee, tea, soda pop, energy drinks): \_\_\_\_\_

Explain \_\_\_\_\_

Does child use tobacco: Yes \_\_\_\_ No \_\_\_\_ If yes, explain \_\_\_\_\_

Does child use alcohol: Yes \_\_\_\_ No \_\_\_\_ If Yes, explain: \_\_\_\_\_

Does child use any recreational substances not prescribed to you by a doctor: Yes \_\_\_\_ No \_\_\_\_

Explain: \_\_\_\_\_

History of substance abuse: Yes \_\_\_\_ No \_\_\_\_ Explain: \_\_\_\_\_

Family history of substance abuse: Yes \_\_\_\_ No \_\_\_\_ Explain: \_\_\_\_\_

**RULES/RESPONSIBILITIES/RELATIONSHIPS:**

How does child deal with rules, responsibilities, and chores? \_\_\_\_\_

Does child obey curfew? \_\_\_\_\_ Has child threatened/attempted to run away or stay out at night? \_\_\_\_\_

How do you deal with child's misbehavior? \_\_\_\_\_

Do you or your spouse/partner believe in physical discipline? \_\_\_\_\_

Has the family ever been involved with Protective Services? \_\_\_\_\_

Are there any situations at home that might have an effect on child's behavior? \_\_\_\_\_

Therapist/Credentials: \_\_\_\_\_ Date: \_\_\_\_\_