CHILD/ADOLESCENT Personal History Form

Parents, please be sure that this form is completed prior to your first session so that your counselor can gain a better understanding of your background, concerns and goals for counseling. Child/Adolescent

Name:_____ Date of Birth: _____

Address:_____ City:_____ Zip:_____ Home

Phone:_____ Parent Cell Phone: _____

Family History

Father Mother

Name: _____

Age: _____

Highest Grade Level: _____

If deceased, dates: _____

If the child's parents are not currently married, please describe below (dates of adoption, divorce, remarriage, names of step-parents, and/or other relevant information):

_____

_____

Brothers/Sisters Names Age Sex Grade Deceased? Where living?

_____

_____

_____

Are both parents in agreement with bringing him/her for counseling? ____ Yes ___ No

Please describe any recent changes for your family (births, deaths, moves, accidents, etc.):

_____

_____

Treatment Information

Person Completing form: _____Relationship to child:_____

Reason for treatment: _____
_____

Previous Treatment? ___ Yes ___ No If yes, please explain: _____
_____

How does your child/adolescent feel about counseling at this time? _____
_____

In what way would you like counseling to help your child/adolescent? _____
_____

What family members are likely willing to participate in your child's counseling? _____
_____

Developmental and Educational Background

Did your child generally meet developmental milestones (i.e., walking, talking, etc.) on time? _____

Explain any developmental concerns: _____

Current Grade:_____ Name of School: _____

Please describe any difficulties your child/adolescent is having in school: _____
_____

Has your child ever been psychologically tested? _____ When? _____

Religious and Spiritual Background

Does your child/adolescent attend church? _____ Name of church: _____

What role does spirituality play in his/her life? _____

Medical Background and History

Physician: _____ City: _____

Last seen (approximately): _____ for _____

On-going Medical Conditions: _____

Is your child/adolescent taking any prescription medication? Medication: _____
Treating: _____ Dosage: _____ Since: ____ Medication: _____

Treating: _____ Dosage: _____ Since: ____ Side effects?
_____

Has your child had a hearing exam? _____ Eye exam? ____ Any problems discovered? _____

Has your child used drugs or alcohol? ____ Has this use ever caused a problem? _____

Family history of substance abuse? ____ Explain: _____

Please check any areas of concern:

___ Moody ___ Concentration ___ Anxious/worries ___ Can't fall asleep ___ Shy ___ Appetite too low ___ Defiant ___ Can't stay asleep ___ Has been bullied ___ Has bullied others ___ Sad ___ Low energy level ___ Has been abused ___ Has abused others ___ Homicidal or Suicidal thoughts

Please explain any of the above: _____

Please check areas of relative strength or giftedness:

___ Compassionate ___ Creative ___ Sensitive ___ Sense of Humor ___ Insightful ___ Loving ___ Determined ___ Independent ___ Academics ___ Reading ___ Math ___ Science ___ Athletic ___ Coordinated ___ Reflective ___ Social

Please explain any of the above: _____

Is there anything else that would be good for your counselor to know? ____ (Use back to explain.)

_____

Signature Date