

**Christian Counseling and Educational Foundation- Montana**

Phone: 406-294-5533 ● office@ccefmt.org

**Personal History— for Children and Adolescents**

Minor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Gender: \_\_\_ F    \_\_\_ M Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Grade in school: \_\_\_\_\_\_

Form completed by (if someone other than the minor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Phone (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext: \_\_\_\_\_\_\_\_ **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:

\_\_\_ Addictive behaviors

\_\_\_ Alcohol/drugs

\_\_\_ Anger management

\_\_\_ Anxiety

\_\_\_ Coping

\_\_\_ Depression

 \_\_\_ Eating disorder

\_\_\_ Fear/phobias

\_\_\_ Hyperactivity

\_\_\_ Mental confusion

\_\_\_ Sexual concerns

\_\_\_ Sleeping problems

\_\_\_ Other mental health concerns (Specify):
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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

Is there any significant information about the parents’ relationship or treatment toward the child which might be beneficial in the counseling process? \_\_\_ Yes    \_\_\_ No

If Yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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    \_\_\_ Step-parent \_\_\_ 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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    \_\_\_ Step-parent \_\_\_ 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Siblings**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  Name |  Age  |  Gender |  Lives | Quality of relationship with the counselee |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ | \_\_ 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 Who Live in the Household**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name  | Age | Gender | Relationship | Quality of relationship with the counselee |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ | \_\_ 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

\_\_\_\_ 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

\_\_\_\_ Perpetual Motor Disorder

\_\_\_\_ Seizures

\_\_\_\_ Spinal Bifida

\_\_\_\_ Suicide

\_\_\_\_ Other (Specify):

\_\_\_\_ Comments: \_\_\_\_\_\_\_\_\_\_\_

**Childhood/Adolescent History**

**Pregnancy/Birth**

Has the child’s mother had any occurrences of miscarriages or stillborns? \_\_\_ Yes    \_\_\_ No

If Yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the pregnancy with child planned? \_\_\_ Yes    \_\_\_ No Length of pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother and father’s age at child’s birth: \_\_\_\_\_\_ \_\_\_\_\_\_ Child number \_\_\_\_\_\_ of \_\_\_\_\_\_ total children.

How many pounds did the mother gain during the pregnancy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_ Bottle fed

\_\_\_\_ Colic

\_\_\_\_ Constipation

\_\_\_\_ Cried often

\_\_\_\_ Diarrhea

\_\_\_\_ Irritable when awakened

\_\_\_\_ Lethargic

\_\_\_\_ Milk allergies

\_\_\_\_ Not cuddly

\_\_\_\_ Overactive

\_\_\_\_ Rashes

\_\_\_\_ Rarely cried

\_\_\_\_ Resisted solid food

\_\_\_\_ Trouble sleeping

\_\_\_\_ Vomiting

**Developmental History**

Please note the age at which the following behaviors took place:

Sat alone: \_\_\_\_\_\_\_ Took 1st steps: \_\_\_\_\_\_\_ Tied shoelaces: \_\_\_\_\_\_\_

Spoke words: \_\_\_\_\_\_\_ Spoke sentences: \_\_\_\_\_\_\_ Rode two-wheeled bike: \_\_\_\_\_\_\_

Weaned: \_\_\_\_\_\_\_ Fed self: \_\_\_\_\_\_\_ Dressed self: \_\_\_\_\_\_\_

Toilet trained: \_\_\_\_\_\_\_ Weaned: \_\_\_\_\_\_\_ Dry during day: \_\_\_\_\_\_\_ Dry during night: \_\_\_\_\_

Compared with others in the family, child’s development was: \_\_\_\_\_ Slow \_\_\_\_\_ Average \_\_\_\_\_ Fast

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.)

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

**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

\_\_\_\_ Bored

\_\_\_\_ Eager

\_\_\_\_ Enthusiastic

\_\_\_\_ Fearful

\_\_\_\_ No expression

\_\_\_\_ Passive

\_\_\_\_ Rebellious

\_\_\_\_ Other (Describe):

**Approach to School Work:**

\_\_\_\_ Cooperative

\_\_\_\_ Disorganized

\_\_\_\_ Does only what is expected

\_\_\_\_ Doesn’t complete assignments

\_\_\_\_ Industrious

\_\_\_\_ Interested

\_\_\_\_ Not initiative

\_\_\_\_ Organized

\_\_\_\_ Refuses

\_\_\_\_ Responsible

\_\_\_\_ Self-directed

\_\_\_\_ Sloppy

\_\_\_\_ Other (Describe):

**Performance in School (Parent’s Opinion):**

\_\_\_\_ Underachiever

\_\_\_\_ Satisfactory

\_\_\_\_ Overachiever

\_\_\_\_ Other (Describe):

**Child’s Peer Relationships:**

\_\_\_\_ Follower

\_\_\_\_ Leader

\_\_\_\_ Shares easily

\_\_\_\_ Spontaneous

\_\_\_\_ Long-time friends

\_\_\_\_ Makes friends easily

\_\_\_\_ Difficulty making friends

\_\_\_\_ Other (Describe):

**Who handles responsibility for your child in the following areas?**

School:

Health:

Problem behavior:

\_\_\_\_ Mother

\_\_\_\_ Mother

\_\_\_\_ Mother

\_\_\_\_ Father

\_\_\_\_ Father

\_\_\_\_ Father

\_\_\_\_ Shared

\_\_\_\_ Shared

\_\_\_\_ Shared

\_\_\_\_ Other (Specify):

\_\_\_\_ Other (Specify):

\_\_\_\_ 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 \_\_\_\_ Hayfever \_\_\_\_ 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nutrition**

Meal How often Typical foods eaten Typical amount eaten

 (times per week)

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 of most recent visit Results

Physical examination \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental examination \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision examination \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hearing examination \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current prescribed medications Dose Dates Purpose Side effects
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_
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Current over-the-counter meds Dose Dates Purpose Side effects
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_
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Immunization record (check immunizations the child/adolescent has received):

DPT: \_\_\_\_ 2 months \_\_\_\_ 4 months \_\_\_\_ 6 months \_\_\_\_18 months \_\_\_\_4-5 years

Polio: \_\_\_\_ 2 months \_\_\_\_ 4 months \_\_\_\_ 6 months \_\_\_\_18 months \_\_\_\_4-5 years

MMR: \_\_\_\_ 15 months HBPV (Hib): \_\_\_\_ 24 months HepB: \_\_\_\_ Prior to school

**Chemical Use History**

Does the child/adolescent use or have a problem with alcohol or drugs? \_\_\_ Yes    \_\_\_ No
If Yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Licensed Counseling/Prior Treatment History**

Information about child/adolescent (past and present):

 Yes No When Where Reaction/overall

experience

Counseling/Psychiatric treatment \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suicidal thoughts/attempts \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug/alcohol treatment \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalizations \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **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

\_\_\_\_ 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 problem 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?
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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What are your goals for the child’s counseling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What family involvement would you like to see in counseling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you believe the child is suicidal at this time? \_\_\_ Yes    \_\_\_ No If Yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you support your children being in counseling sessions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much involvement would you like to have in the counseling process? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Parent’s Signature & Consent for Counseling:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_