North East Counseling and Trauma Services

Personal History—Children and Adolescents

Client's name:_____Date:_____

Gender:_____ Date of birth:_____ Age:_____ Grade in school: _____

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

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:

___ Anger management ___Anxiety ___Coping ___Depression

___ Eating disorder ___Fear/phobias ___confusion ____Sexual concerns

___ Sleeping problems ___Addictive behaviors. ___Alcohol/drugs ___Hyperactivity

___ Other mental health concerns (specify): _____

_____

Family History

Parents

With whom does the child live at this time? _____

Are parent's 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 counseling?_____Yes _____No

If Yes, describe: _____

Primary Caregiver:

Name:_____Age:____ Occupation:_____ ___FT ___PT

Where employed:_____ Work phone: _____

Is the child currently living with caregiver?_____Yes_____No Relationship to Patient:

___ Biological parent ___ Step-parent ____Adoptive parent __Foster home

___ Other (specify): _____

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

___ Yes_____No

If Yes, please explain: _____

Address: 57 North Street, Suite 217, Danbury, CT. 06810

Tel: (860) 841-6574 • **Fax:** (860) 606-953

Primary Caregiver

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Where employed:_____ Work phone: _____

Is the child currently living with caregiver?_____Yes_____No Relationship to Patient:

___ Biological parent ____ Step-parent ____Adoptive parent ___Foster home

___ Other (specify): _____

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

___ Yes_____No

If Yes, please explain: _____

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives		Quality of relationship with the client		
_____	___	_____	___ home	_____ away	___ poor	___ average	_____ good
_____	___	_____	___ home	_____ away	___ poor	___ average	_____ good
_____	___	_____	___ home	_____ away	___ poor	___ average	_____ good
_____	___	_____	___ home	_____ away	___ poor	___ average	_____ good

Others living in the household			Relationship (e.g., cousin, foster child)			
_____	___	_____	_____	___poor	___ average	__ good
_____	___	_____	_____	___poor	___ average	__ good
_____	___	_____	_____	___poor	___ average	__ good
_____	___	_____	_____	___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	___ Deafness	___ Muscular Dystrophy
___ Anemia	___ Diabetes	___ Nervousness
___ Asthma	___ Glandular problems	___ Perceptual motor disorder
___ Bleeding tendency	___ Heart diseases	____ Spinal Bifida
___ Blindness	___ High blood pressure	___ Suicide
___ Cancer	___ Kidney disease	___ Other (specify): _____
___ Cerebral Palsy	___ Mental illness	___
___ Cleft lips	___ Migraines	
___ Cleft palate	___ Multiple sclerosis	

Comments re: Family Health: _____

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: _____

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: _____

Check the descriptions which specifically relate to your child.

Feelings about School Work:

___ Anxious ___Passive ___Enthusiastic ___Fearful

___ Eager ___No expression ___Bored ___Rebellious

___ Other (describe): _____

Approach to School Work:

___ Organized ___ Industrious ___ Responsible ___ Interested

___ Self-directed ___ No initiative ___ Refuses ___ Does only what is expected

___ Disorganized ___ Cooperative ___ Doesn't complete assignments

___ Other (describe): _____

Performance in School (Parent's Opinion):

___ Satisfactory ___Unsatisfactory

___ Other (describe): _____

Child's Peer Relationships:

___ Spontaneous ___Follower ___Leader ___Difficulty making friends

___ Makes friends easily_____Long-time friends____Shares easily

___ Other (describe): _____

Who handles responsibility for your child in the following areas?

School	Caregiver:	Shared: Yes or No	Other (specify):
Health	Caregiver:	Shared: Yes or No	Other (specify):
Problem Behavior	Caregiver:	Shared: Yes or No	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

____ Asthma	____ Hayfever	____ Pneumonia
____ Bronchitis	____ Heart trouble	____ Polio
____ Cerebral Palsy	____ Hepatitis	____ Scarlet Fever
____ Chicken Pox	____ Hives	____ Seizures
____ Congenital problems	____ Influenza	____ Severe colds
____ Croup	____ Lead poisoning	____ Severe head injury
____ Diabetes	____ Measles	____ Sexually transmitted disease
____ Diphtheria	____ Meningitis	____ Thyroid disorders
____ Dizziness	____ Blackouts	____ Vision problems
____ Earaches	____ Multiple sclerosis	____ Wearing glasses
____ Ear infections	____ Mumps	____ Whooping cough
____ Eczema	____ Muscular Dystrophy	____ Other
____ Encephalitis	____ Nose bleeds	____
____ Fevers	____ Other skin rashes	
	____ Paralysis	
	____ Pleurisy	

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

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

Current over-the-counter medications & supplements	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

	Yes	No	When	Where	Reaction or 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
___ 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
___ Drugs dependence
___ Eating disorder
___ Enthusiastic
___ 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
___ Messy
___ Moody
___ Nightmares
___ Obedient
___ Often sick
___ Oppositional
___ Overactive
___ Overweight
___ Panic attacks
___ Phobias
___ Poor appetite
___ Low self-esteem
___ Sad
___ Selfish
___ Separation anxiety
___ Sets fires
___ Sexual acting out
___ Shares
___ Sick often
___ Short attention span
___ Shy, timid
___ Sleeping problems
___ Slow moving
___ Speech problems
___ Steals
___ Stomach aches
___ 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? _____

_____

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?

_____

_____

_____

What are your goals for the child's therapy? _____

_____

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

_____

Do you believe the child is suicidal at this time?_____Yes ____No

If Yes, explain: _____

_____