

Prince William Family Counseling

Personal History—Children and Adolescents

Client's name: _____ Date: _____

Gender: ___F___ M 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 Attention Coping
 Depression Eating disorder Fear/phobias Mental 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: _____

CLIENT'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 : _____

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How is the child disciplined by the mother? _____

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

CLIENT'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? _____

CLIENT'S SIBLINGS AND OTHERS WHO LIVE IN THE HOUSEHOLD

Name of Siblings	Age	Gender	Lives	Quality of relationship with the client
_____	___	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	___	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	___	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	___	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good

Others living in the household

Relationship (e.g., cousin, foster child)

_____ F M _____ poor average good

_____ F M _____ poor average good

_____ F M _____ poor average good

_____ F M _____ poor average good

Comments: _____

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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:

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Deafness | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glandular problems | <input type="checkbox"/> Perceptual motor disorder |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Heart diseases | <input type="checkbox"/> Intellectual disability |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Spina bifida |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Cleft lips | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Multiple sclerosis | _____ |
| <input type="checkbox"/> Comments re: Family Health: _____ | | |

CHILDHOOD/ADOLESCENT HISTORY

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.

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 or 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: _____

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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
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: _____

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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): _____

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): _____

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: _____

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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

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

List any current health concerns: _____

List any recent health or physical changes: _____

NUTRITION

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High
Lunch	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High
Dinner	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High
Snacks	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High

Comments: _____

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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 meds	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

Information about child/adolescent (past and present):

	Yes	No	When	Where	Reaction or overall experience
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____

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BEHAVIORAL/EMOTIONAL

Please check any of the following that are typical for your child:

- | | | |
|---|---|---|
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Frustrated easily | <input type="checkbox"/> Sad |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Gambling | <input type="checkbox"/> Selfish |
| <input type="checkbox"/> Alcohol problems | <input type="checkbox"/> Generous | <input type="checkbox"/> Separation anxiety |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sets fires |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Head banging | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Attachment to dolls | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Sexual acting out |
| <input type="checkbox"/> Avoids adults | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Shares |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Hurts animals | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Blinking, jerking | <input type="checkbox"/> Imaginary friends | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Bizarre behavior | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Shy, timid |
| <input type="checkbox"/> Bullies, threatens | <input type="checkbox"/> Irritable | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Careless, reckless | <input type="checkbox"/> Lazy | <input type="checkbox"/> Slow moving |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Soiling |
| <input type="checkbox"/> Clumsy | <input type="checkbox"/> Lies frequently | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Confident | <input type="checkbox"/> Listens to reason | <input type="checkbox"/> Steals |
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Loner | <input type="checkbox"/> Stomachaches |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Suicidal threats |
| <input type="checkbox"/> Defiant | <input type="checkbox"/> Messy | <input type="checkbox"/> Suicidal attempts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Moody | <input type="checkbox"/> Talks back |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Obedient | <input type="checkbox"/> Thumb sucking |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Often sick | <input type="checkbox"/> Tics or twitching |
| <input type="checkbox"/> Drug dependence | <input type="checkbox"/> Oppositional | <input type="checkbox"/> Unsafe behaviors |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Overactive | <input type="checkbox"/> Unusual thinking |
| <input type="checkbox"/> Enthusiastic | <input type="checkbox"/> Overweight | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Excessive masturbation | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Expects failure | <input type="checkbox"/> Phobias | <input type="checkbox"/> Worries excessively |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Psychiatric problems | _____ |
| <input type="checkbox"/> Frequent injuries | <input type="checkbox"/> 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: _____

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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 at risk to himself/herself or others? ___ Yes ___ No

If Yes, explain: _____

FOR STAFF USE

Therapist's comments: _____

Therapist's signature/credentials: _____

Date: ___/___/_____