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PERSONAL HISTORY- CHILDREN/ADOLESCENTS

Client's name: _____ Date: _____
Gender: ___ F ___ M Date of Birth: _____ Age: _____ Grade in school: _____
Form completed by (if someone other than client): _____

Primary reason(s) for seeking services:

- Anger management Anxiety Coping Depression
 Eating disorder Fear/phobias Family Conflict Noncompliance
 Sleeping problems Obsessive/Compulsive behaviors Alcohol/drugs
 Hyperactivity School Problems Social Problems Trauma
 Other 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? _____

Client's Mother

Name: _____ Age: _____ Occupation: _____ ___ FT ___ PT
Where employed: _____ Work phone: _____
Mother's education: _____
Is the child currently living with mother? ___ Yes ___ No
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? _____

Client's Father

Name: _____ Age: _____ Occupation: _____ ___ FT ___ PT
Where employed: _____ Work phone: _____

Father's education: _____

Is the child currently living with father? Yes No

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? _____

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
_____	___	___ 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 living in the household	Relationship (e.g., cousin, foster child)	Quality of relationship with the client
_____	___ F ___ M _____	___ poor ___ average ___ good
_____	___ F ___ M _____	___ poor ___ average ___ good

Comments: _____

Who handles responsibility for this child in the following areas?

School: Mother Father Shared Other (specify): _____

Health: Mother Father Shared Other (specify): _____

Problem behavior: Mother Father Shared Other (specify): _____

Family Health/Mental 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:

- Depression Anxiety Autism/Other PDD
- ADHD Schizophrenia Bipolar Disorder
- Migraines Muscular Dystrophy Seizures
- Suicide Mental Retardation Other (specify): _____
- Cancer Stomach Problems Other (specify): _____

Comments re: Family Health/Mental Health _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? Yes No

If Yes, describe: _____

Spiritual/Religious

How important to you are spiritual matters? Not Little Moderate Much

Are you affiliated with a spiritual or religious group? _____

Would you like your spiritual/religious beliefs incorporated into the counseling? Yes No
If Yes, describe: _____

Childhood/Adolescent History

Pregnancy/Birth

Was the pregnancy with child planned? Yes No
Length of pregnancy: _____ Baby's birth weight: _____
Mother's age at child's birth: _____ Father's age at child's birth: _____
Child number of total children.
While pregnant did the mother smoke or 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: _____
Describe any physical or emotional complications with the delivery or after the birth: _____

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:

Toilet Trained: _____ Spoke Words: _____
Took 1st steps: _____ Fed Self: _____
Compared with others in the family, child's development was: slow average fast
Injuries or hospitalizations: _____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

Education

Current school: _____ Grade: _____
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: _____

Approach to School Work:

Organized Industrious Responsible Interested
 Self-directed No initiative Refuses Does only what is expected
 Sloppy Disorganized Cooperative Doesn't complete work
 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 Long-time friends Shares easily
 Other (describe): _____

Vocational:

Vocational Interests: _____

Plan (i.e. college, trade school, internship): _____

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?
_____	_____	_____
_____	_____	_____
_____	_____	_____

What are the family's favorite activities? _____

What does the child/adolescent do with unstructured time? _____

Health History

List any current health concerns: _____

List any recent health or physical changes: _____

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	_____	_____	_____	_____	_____
Psychotropic Medication	_____	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____	_____
Psych Hospitalizations	_____	_____	_____	_____	_____

Comments: _____

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"/> Stomach aches |
| <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"/> Drugs dependence | <input type="checkbox"/> Oppositional | <input type="checkbox"/> Unsafe behaviors |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Over active | <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: _____

Have there been any other significant changes or events in your child's life? (family, moving, fire, deaths, etc.) Yes No If Yes, describe: _____

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: _____

For Therapist's Use Only

Reviewed by:	Date:
Therapist's signature/credentials:	