# CHILD/ADOLESCENT PERSONAL HISTORY
## (AGES 17 AND UNDER)

Today's Date: _____ Your Name: _____

Child's Name: _____ Age: _____

How are you related to the child? _____

| | | AGE |
|---|---|---|
| Child's Parents: | _____ | _____ |
| Step-parents: | _____ | _____ |
| Child's Brothers and Sisters:<br>B=Brother<br>S=Sister<br>SB=Step-brother<br>SS=Step-sister<br>HB=Half-brother<br>HS=Half-sister | _____<br>_____<br>_____<br>_____ | _____<br>_____<br>_____<br>_____ |

Child was raised by: _____

Who lives in child's main household? _____

_____

Whose idea was it to bring child to clinic? _____

What problems is your child having? _____

_____

_____

_____

When has he/she been having these problems? _____

Why do you think your child is having problems? _____

_____

Describe how child's problems affect you, other family members, others: _____

_____

_____

_____

What would you or referring person like to see done for your child? _____

When and where has your child been evaluated or counseled before? _____

_____

Reason: _____

Has child ever threatened/attempted to harm self or others?_____

Explain: _____

Have child's parents or any close relatives ever been in counseling at a clinic or been hospitalized for depression, hearing voices, alcohol or drug problems, suicide attempts, etc? Please explain who, where, when:

Who? _____ When? _____ Where? _____ Why? _____

Who? _____ When? _____ Where? _____ Why? _____

Who? _____ When? _____ Where? _____ Why? _____

How is child's physical health? _____

Has child had serious illnesses, injuries, surgeries, hospitalizations? _____

Explain: _____

Child's Physician: _____ Phone: _____

Date child last saw physician: _____ Reason:_____

Results of Doctor visit:_____

Immunizations up-to-date: _____

Medications child is on: _____

Child's Height: _____ Weight: _____ Appetite: _____

Describe any recent weight gain/loss:_____

Does child over-eat? _____ Refuse food? _____ Purge? _____

Any food or medication allergies? _____

Child's usual energy/activity level: _____

Was your pregnancy desired? _____ Length of term: _____

Problems during pregnancy (include alcohol/drug usage by mother):_____

_____

Complications during delivery: _____

Explain if mother/child separated after birth: _____

_____

Other parent/child separations:_____

Describe child as an infant/toddler (cheerful, fussy, cuddly, withdrawn): _____

Did child move developmental milestones within the normal range?_____

If no, please explain:_____

School child attends:_____ Grade: _____

In special classes?_____ Since what grade? _____

Learning disabilities? _____

Has child repeated any grades? _____ Which grades?_____

Describe attendance:_____

Describe effort/attitude toward school: _____

Describe academic performance: _____

Describe behavior in school:_____

When did school performance/behavior change?_____

Why do you think it changed? _____

Education of each parent/guardian: _____

_____

Employment/training/work hours of each parent/guardian:

You: _____

Spouse/partner: _____

Ethnic/Cultural background of child: _____

Religious/Spiritual background: _____

Legal problems of child (past and present): _____

_____

Parent/Child Relationship:_____

How do you and spouse/partner show affection to child? _____

_____

If one of child's biological parents is out of the home, describe his/her relationship with child: _____

_____

Responsibities/Rules:_____

_____

How does child handle these? _____

Has child threatened/attempted to run away or stayed out all night? _____

Explain: _____

What do you and your spouse/partner DO when your child misbehaves?

You: _____

Spouse/partner: _____

Describe any behavior of family members in the home (drinking, drugs, verbal or physical conflict, suicide attempts, etc.) that may have affected your child: _____

_____

_____

_____

_____

Describe any events--family illness, death, separation, divorce, move to a different neighborhood or school, change in family finances, etc.-- that may have affected your child: _____

_____

_____

Please review the following list and circle those you feel fit your child:

1. Speech difficulties
2. Nervous habits/behavior
3. Frequent headaches
4. Frequent stomach-aches
5. Difficulty sleeping
6. Lacks guilt/remorse
7. Difficulty making friends
8. Difficulty keeping friends
9. Little interest in friends
10. Little interest in activities
11. Disrespectful/argumentative
12. Doesn't complete schoolwork
13. Acts before thinking
14. Short attention-span
15. Unable to sit still
16. Overactive
17. Underactive
18. Sucks thumb
19. Bangs head
20. Grinds teeth
21. Nightmares
22. Seems angry
23. Hurts animals
24. Sets fires
25. Steals
26. Lies a lot
27. Too serious
28. Fights a lot
29. Clowns a lot
30. Acts spoiled
31. Temper tantrums
32. In own world
33. Afraid/fearful
34. Accident-prone
35. Seems insecure
36. Sad/depressed
37. Worries a lot
38. Cries frequently
39. Mentally slow
40. Interested in sex
41. Looks "high" often
42. Separation problems
43. Imaginary friends
44. Ignores rules
45. Defies authority

Interests/Activities (Please circle or check):

| | | | | |
|---|---|---|---|---|
| Watch television | Play sports | Sew | Skate | Baby-sitting |
| Be with friends | Ride Bicycle | Draw | Write | Imaginary play |
| Play video games | Roller blade | Read | Scouts | Action figures |
| Listen to music | Build things | Sing | School | Power Rangers |
| Talk on phone | Collect things | Dance | Crafts | Dolls |

Other: _____

Activities/Interests child no longer enjoys: _____

Client strengths or skills: _____

_____

If there has been any drug or alcohol use, please complete the following:

| TYPE OF DRUG | AGE OF 1ST USE | WHAT AGE WAS CHILD USING IT REGULARLY | AVERAGE NUMBER OF DAYS USED EACH WEEK | ABOUT HOW MUCH WOULD CHILD USE EACH DAY | # DAYS USED IN PAST 30 DAYS | LAST DATE CHILD USED |
|---|---|---|---|---|---|---|
| Coffee, Cola<br>Caffeine pills | | | | | | |
| Cigarettes | | | | | | |
| Beer<br>Wine<br>Liquor | | | | | | |
| Marijuana | | | | | | |
| Crack cocaine<br>51's<br>Cocaine powder | | | | | | |
| Heroin: Snort<br>Snoot | | | | | | |
| Methadone | | | | | | |
| Pain Medication<br>Type: | | | | | | |
| Tylenol #3 or 4 | | | | | | |
| Muscle Relaxers<br>Soma, Flexeril<br>Other: _____ | | | | | | |
| Valium, Librium<br>Other: _____ | | | | | | |
| Glue<br>Poppers<br>Aerosols | | | | | | |
| PCP<br>LSD<br>Mescaline | | | | | | |
| Meth-amphetamine | | | | | | |
| Phenobarbital<br>Sleeping pills | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Steroids | | | | | | |
| Other: | | | | | | |

Therapist/Credentials: _____ Date: _____