



Child/Adolescent Background & History

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 ___ Alcohol/drugs ___ Addictive behaviors ___ Anxiety
___ Attention Problems ___ Autism Spectrum ___ Challenging behavior ___ Coping skills
___ Depression ___ Eating disorder ___ Fear/phobias ___ Hyperactivity
___ Learning problems ___ Mental confusion ___ Relationship problems ___ Sexual concerns
___ Sleeping problems ___ Social skills

___ 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 that 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

___ Biological 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: _____

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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

Biological 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? _____

Client's Siblings and Others Who Live in the Household

Names 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)

_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good

Comments: _____

Family Health History

Have any of the following diseases or disorders occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those that apply:

<input type="checkbox"/>	Addiction	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	Muscular Dystrophy
<input type="checkbox"/>	ADHD	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Developmental Disability	<input type="checkbox"/>	Perceptual motor disorder
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Mental Retardation
<input type="checkbox"/>	Anxiety Disorder	<input type="checkbox"/>	Glandular problems	<input type="checkbox"/>	Schizophrenia
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Heart diseases	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Autism Spectrum Disorder	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Speech/language delay
<input type="checkbox"/>	Bi-Polar Disorder	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	Spinal Bifida

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<input type="checkbox"/>	Bleeding tendency	<input type="checkbox"/>	Learning problems	<input type="checkbox"/>	Suicide
<input type="checkbox"/>	Blindness	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Other (specify):
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>	
<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	Cleft lips/palate	<input type="checkbox"/>		<input type="checkbox"/>	

Comments about family health: _____

Childhood/Adolescent History

Pregnancy/Birth

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 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:

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Breast fed | <input type="checkbox"/> Milk allergies | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bottle fed | <input type="checkbox"/> Rashes | <input type="checkbox"/> Colic | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Not cuddly | <input type="checkbox"/> Cried often | <input type="checkbox"/> Rarely cried | <input type="checkbox"/> Overactive |
| <input type="checkbox"/> Resisted solid food | <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Irritable when awakened | <input type="checkbox"/> Lethargic |

Other: _____

Developmental History Please note the approximate age at which the following behaviors took place:

- | | |
|----------------------------------|------------------------------|
| Sat alone: _____ | Dressed self: _____ |
| Took 1st steps: _____ | Tied shoelaces: _____ |
| Spoke words: _____ | Rode two-wheeled bike: _____ |
| Spoke sentences: _____ | Toilet trained: _____ |
| Weaned from bottle/breast: _____ | Dry during day: _____ |
| Fed self: _____ | Dry during night: _____ |

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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 (please provide a copy of the report): _____

Check the descriptions that 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

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 Long-time friends Shares easily

Other (describe): _____

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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: _____

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: _____

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List any recent health or physical changes: _____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	___ / week	_____	___ No	___ Low	___ Med	___ High
Lunch	___ / week	_____	___ No	___ Low	___ Med	___ High
Dinner	___ / week	_____	___ No	___ Low	___ Med	___ High
Snacks	___ / week	_____	___ No	___ Low	___ Med	___ High

Comments: _____

How would you describe your child's appetite? _____

Have you noticed recent changes in your child's appetite or eating habits? Please explain: _____

Sleep

Typical time child goes to bed _____ Typical time child falls to sleep _____ Typical time child wakes up _____

Falls asleep easily? _____ Wakes up easily? _____

Does your child nap? Please describe: _____

Have your child's sleep habits changed recently? Please explain: _____

Comments/concerns about your child's sleep: _____

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	_____	_____	_____	_____	_____

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 |

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- | | | |
|---|---|--|
| <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: _____

Has there been any history of abuse, neglect, or other trauma? 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: _____

For Staff Use

Therapist's comments: _____

Therapist's signature/credentials: _____ Date: ____/____/____

