HISTORY FORM
Child/Adolescent

Parent completes this section:

Child/Adolescent's Name_____Birth Date_____

Address_____

City_____ State_____ Zip Code_____ Phone _____

What is the primary cultural background with which he/she most closely identifies?
□ Caucasian □ Black/African American □ Hispanic/Latino □ Asian □ Biracial
□ Other_____

Mother's Name_____
Address:_____
City_____State_____ Zip Code_____ Phone _____

What is the primary cultural background with which the mother most closely identifies?
□ Caucasian □ Black/African American □ Hispanic/Latino □ Asian □ Biracial
□ Other: ___

Father's Name_____
Address_____
City_____ State_____ Zip Code_____ Phone _____

What is the primary cultural background with which the father most closely identifies?
□ Caucasian □ Black/African American □ Hispanic/Latino □ Asian □ Biracial
□ Other_____

Parent's Relationship Status:
□ Single □ Partner □ Married □ Divorced □Widowed □ Separated □ Cohabitating and unmarried
Length of parent's relationship _____year(s) _____month(s)
If parents are divorced, please list the visitation schedule here: _____
_____

Primary Custodial Parent or Guardian (If different than above):_____
Relationship to child/adolescent: _____
Address _____
City_____State_____ Zip Code_____ Phone _____

What has led you to seek counseling at this time?
_____
_____
_____
_____

Please list your child/adolescent's strengths:

_____

_____

Please let us know if any of the following are problem areas for your child:

□ Self-injurious behavior □ School problems □ Depression/Anxiety □ Family problems
□ Acting out behaviors □ Health problems □ Physical or sexual abuse □ High Risk Behaviors
□ Attention problems □ Aggressive behavior □ Social Problems □ Substance Abuse
□ Other

_____

Family History:

Does your child/adolescent have stepparents? □Yes □ No
If yes, list names and ages:
Step-Mother/Age _____/ _____ Step–Father/Age _____/_____
How would you describe his/her relationship with his/her stepparent? □ Excellent □ Good □ Fair □ Poor

Sibling(s):

1. Name: _____ Age:_____
□ Biological □ Step □ Other □ Living □ Deceased
How would you describe their relationship? □ Excellent □ Good □ Fair □ Poor
2. Name: _____ Age:_____
□ Biological □ Step □ Other □ Living □ Deceased
How would you describe their relationship? □ Excellent □ Good □ Fair □ Poor
3. Name: _____ Age:_____
□ Biological □ Step □ Other □ Living □ Deceased
How would you describe their relationship? □ Excellent □ Good □ Fair □ Poor
4. Name: _____ Age:_____
□ Biological □ Step □ Other □ Living □ Deceased
How would you describe their relationship? □ Excellent □ Good □ Fair □ Poor

Other siblings:

_____

_____

Education:

School: _____ City: _____ Grade: _____
Is the child/adolescent in any special education/ exceptional education program? □ Yes □ No
If yes, what kind of program?

_____

Does he/she have an Individualized Educational Plan (IEP)? □Yes □No
Has he/she ever had any disciplinary problems in school? □ Yes □ No
If yes, check all the following that apply:
□ Suspension □ Expulsion □ Referrals □ Alternative schools (i.e., Excel) □ Other _____
Please describe:

_____

How would you rate your child/adolescent's school experience on a scale from 1-5 where 1 is extremely negative and 5 is extremely positive?

□1 □ 2 □ 3 □ 4 □ 5

Negative Average Very Positive

Medical History:

Has your child/adolescent ever had:

□ Physical injury □Yes, one physical injury □ Yes, more than one □ No

If yes, please describe

_____

□ Major Illness □ Yes, one major illness □ Yes, more than one □ No

If yes, please describe

_____

How would you describe your child/adolescent's current health? □ Excellent □ Good □ Fair □ Poor

Does your child/adolescent take any prescription medications? □ Yes □ No

Please list:

_____

_____

Does your child/adolescent take any over the counter or herbal medication? □ Yes □ No

Please list:

_____

Has your child/adolescent received outpatient psychiatric/psychological/counseling in the past? □ Yes □ No

If yes, please describe: _____

_____

Has your child/adolescent ever been in the hospital for psychiatric/ psychological problems? □ Yes □ No

If yes, please describe: _____

_____

Has a physician ever recommended any anti-anxiety, anti-depressant, ADHD, or anti-psychotic medication for your child/adolescent? □ Yes □ No

If yes, please describe_____

_____

Has your child/adolescent ever been abused or experienced a trauma? □ Yes □ No

If yes, please describe_____

_____

Did your child/adolescent reach developmental milestones at expected time frames?

Walking □ Yes □ No Talking □ Yes □ No

Toilet Training □ Yes □ No Sleeping Independently □ Yes □ No

Able to separate from parent □ Yes □ No Independent self-care/hygiene □ Yes □ No

Ability to follow multi-step directions □ Yes □ No

Is there anything I should know about your child that has not been asked on this form? If yes, describe:

_____

_____

_____

_____

_____

This section is optional for Adolescents/Teens and can be turned in directly to the psychologist if preferred:

Substance Use:

Have you ever used drugs or alcohol? □ Yes □ No
If yes, what kind?
□ Wine □ Beer □ Liquor □ Ecstasy □ Acid □ Speed □ Downers
□ Prescription Drugs □ Marijuana □ Cocaine
□ Other:_____

At what age did you first use? Please explain:
_____
_____

Have you ever used drugs before or during school? □ Yes □ No
Have you ever missed school because of use or just to use? □ Yes □ No
Do you ever feel pressure to use? □ Yes □ No
About how often do you get high or drunk?_____
About how often do you use more than one drug when you get high? _____

Abuse /Trauma History:
Have you ever been physically abused? □Yes □No
Have you ever been sexually abused? □Yes □No
Have you ever been emotionally or mentally abused? □Yes □ No
Are you not sure what this is and want to learn more about it?_____
Have you ever experienced any other severe trauma? □Yes □ No
If yes, please describe_____

Religious / Spiritual Issues
Are spiritual or religious issues important to you? □ Yes □ No
Do you wish to discuss them in counseling, when relevant? □ Yes □ No

Suicide Assessment
Have you ever attempted suicide? □ Yes □ No
If yes, how long ago was the last attempt _____Year(s) _____Month (s)
If yes, how many times have you attempted suicide? □1 □ 2 □ 3 □ 4 □ More than 4
Do you have current thoughts of ending your life? □Yes □ No
Do you feel you have a support system? □ Yes □ No
If yes, who are they
_____
_____

Is there anything more you would like to report on this form?
_____
_____
_____