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Child and Family History

Form completed by: { } Parent { } Foster Parent { } Guardian { } Other :_____

Are you a single parent? { } Yes { } No

Child's Name: _____ DOB: _____ Age: _____

Gender: { } Male { } Female Grade: _____ Name of School: _____

Referred by: { } Parent/Guardian { } Pediatrician { } School { } EAP { } ACCESS { } CPS

{ } Social Services { } Court Order { } Other: _____

Address: _____ City: _____ Zip Code: _____

Telephone: H _____ W _____ Cell _____

Parent's Email Address: _____

Therapist may leave message at : { } Home { } Work { } Cell { } Email (Preferred:_____)

Race/Ethnicity: _____

Emergency contact person: _____

Relationship: _____ Phone #: _____

I understand that counseling is a process that may take some time and there is no guaranteed benefit. What is shown in research is that it is important to have a trusting relationship with your therapist, provide honest answers, and understand that at times counseling is uncomfortable. Please inform me if this is troubling you. We can see how to resolve it as helpfully as possible.

Type(s) of service desired: { } Child therapy { } Adolescent therapy { } Family therapy

{ } Referral for medication evaluation

Child's main problem/major reason for seeking help at this time: _____

_____

_____

_____

_____

How long has your child had these problems, symptoms, or issues?_____

_____

_____

Has your child had treatment for these issues in the past? { } Yes { } No

If Yes, was the outcome helpful? { } Yes { } No

Has your child had inpatient mental health treatment? { } Yes { } No

Briefly describe treatment including dates, name of facility/therapist, presenting issues and outcome:

_____

_____

_____

Describe any other behavioral or emotional problems your child is having: _____

_____

_____

_____

Describe the impact of your child's problems on the family: _____

_____

_____

Describe your child's strengths and unique qualities: _____

_____

_____

Is your child currently under the care of a physician or psychiatrist? { } Yes { } No

If yes: Doctor's Name: _____ Phone # _____

Treatment for: _____

Is your child currently taking any medications? { } Yes { } No If yes, include the following information:

Name of medications	Dosage	Prescribed by
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does this child have a history of abuse (physical, sexual, emotional, neglect)? { } Yes { } No

If yes, please describe briefly, including dates, location, perpetrators, type of abuse and impact on child/family: _____

Is there legal action pending related to accusations of abuse? { } Yes { } No

If yes, describe briefly: _____

Is there any other legal action that may have impacted your child? Please check all that apply:

	Current	Past		Current	Past
Custody			Visitation		
Adoption			Child Protective Services		
Probation			Other		

If yes, describe briefly: _____

BEHAVIOR CHECKLIST Please check any of the following behaviors that concern you:

Behavior:	Current	Past	Behavior:	Current	Past
Crying, sadness, depression			Temper outbursts		
Loss of enjoyment of usual activities			Irritability, anger		
Expressing a wish to die			Argues a lot		
Bedtime fears, won't sleep			Disobedience		
Has threatened/attempted suicide			Does things that annoy others		
Worries more than others			Unusual fears or phobias		
Panics			Anxious, nervous		
Repeats unnecessary act over and over			Is overly concerned about things		
Has rituals, habits, superstitions			Twitches or unusual movements		
Eats very little/fasts to lose weight			Gorges or binge eats		
Sleepwalking			Blames others for own mistakes		
Withdrawn			Easily annoyed by others		
Nightmares, night terrors			Swears or uses obscene language		
Low self-esteem			Wanting to run away		
Wakes up very early, unable to go back to sleep			Sneaks out at night		
Tiredness, fatigue			Injures self		
Restless sleep, wakes frequently			Stealing		
Trouble going to sleep			Lying		
Sleeps too much			Hurts animals		
Poor appetite			Destroys property		
Under or overweight			Hurts people		
Over-activity			Drug use		
Frequently acts without thinking			Alcohol use		
Doesn't finish things			Cigarette use		
Disruptive			Sexual problems		
Short attention span			Problems with authority		
Daydreams, fantasizes			Problems with the law		
Easily distracted			Low motivation		
Hallucinations			Vomits intentionally		
Bedwetting/daytime wetting			Soiling (pooping) in pants		
Strange or unusual behavioral			Disorientation		

Forms of discipline used in the home: { } Time out { } Loss of privileges { } Grounding

{ } Rewards/incentives { } Extra chores { } Physical/corporal punishment

{ } Other: _____

Relationship Development Check each item that describes your child:

	Current	Past		Current	Past
Prefers to be alone			Is demanding and bossy		
Is alone a lot, but dislikes this and feels lonely			Fights with others		
Is shy			Bullies others		
Has few friends			Teases a lot		
Has many friends			Plays with younger kids		
Plays with "problem kids"			Plays with older kids		
Is picked on a lot			Poor relationships with peers		
Is oversensitive			Conflict with parents/step-parents		
Poor relationships with teachers			Has difficulty getting along with brothers and sisters		

School Check any area of concern:

	Current	Past		Current	Past
Dislikes school			Missed many school days		
Works hard but does not do well			Repeated a grade		
Unmotivated, refuses to complete work			Discipline referrals, detentions		
Learning problems			Suspensions (how many? ___)		
Expulsions (how many? _____)					

If your child has been suspended or expelled, please explain: _____

_____

_____

_____

School Environment Check all that apply:

	Current	Past		Current	Past
Resource classes/special ed.			Continuation school		
Gifted program			Home study		
Speech therapy			Independent study		
Other programs					

If other programs, please explain: _____

_____

_____

Family Stresses Check all that apply:

	Current	Past		Current	Past
Marital problems			Housing problems		
Marital separation			Legal issues		
Divorce			Death of a friend		
Custody disputes			Death of a relative		
Financial problems			Death of a pet		
Job loss			Family illness		
Parents using alcohol/drugs			Other stressors:		

If other stressors, please describe: _____

_____

_____

Developmental History During pregnancy, did mother:

{ } drink { } drugs { } illness { } accident

{ } problems with pregnancy { } problems with labor { } problems with delivery

If yes, please describe: _____

_____

_____

Please check if child is/was delayed in any of the following areas: { } holding head up

{ } turning over { } sitting up { } crawling { } walking alone { } weaning { } feeding self

{ } toilet training { } using single words { } using sentences { } dressing self { } sleeping through night

Briefly explain any delays: _____

_____

_____

_____

As a baby/toddler, was child: check all that apply

{ } eating well { } colicky { }head banging { } performing rocking behavior { } clumsy

{ } easy to regulate (sleeping/eating) { } wanting to be left alone { }adaptable to transitions

{ } more interested in things than people { } easy to soothe { } performing daredevil behavior

Medical History Indicate if your child has had any of the following:

Condition	Yes	No	Age	Details
Serious Infection				
Convulsions/seizures				
Head injuries				
Other injuries				
Hospitalizations				
Surgeries				
Ear infections				
Poisonings				
Allergies				
Asthma				
Alcoholism				
Drug Use				
Sexual Problems				

Does your child have any other medical conditions? { } Yes { } No

If yes, please describe: _____

_____

_____

Does your child frequently complain of bodily aches and pains? { } Yes { } No

If yes, please describe: _____

_____

_____

Does your child miss school because of his/her physical complaints? { } Yes { } No

If yes, please describe: _____

_____

_____

Does your child have any allergies to medications, drugs or foods? { } Yes { } No

If yes, please describe: _____

_____

_____

Family Information: List all of the people who currently live with the child

Name	Age	Relationship	Occupation/School and Grade

Indicate if any family members or relatives have the following:

	Mother		Father		Brother		Sister		Other	
Problem:	Now	Past	Now	Past	Now	Past	Now	Past	Now	Past
Problems with attention, activity or impulse control as a child										
Learning disabilites										
Did not graduate from high school										
Alcohol abuse										
Drug use										
Problems with aggressive behavior as adult or child										
Antisocial behavior (arrests, jail, legal problems, probation, other										
Abuse victim										
Abusive to others										
Depression										
Nervous disorders										
Mental retardation										
Serious illness or surgeries										
Physical handicaps										
Tics or unusual movements										
Other mental problems										

What are your family supports? (church, friends, clubs etc.) _____

_____

_____

What are your family strengths? _____

_____

_____

Additional comments: _____

_____

_____

_____

Please list any adults who are authorized to drop off or pick up your child from his/her therapy session in the event you or another legal guardian are unavailable:

Name	Relationship to child

Please note: An authorized adult must remain in the waiting room at all times when a minor is in a therapy session.

I authorize the above named person(s) to drop off or pick up my child from his/her therapy session. I agree that I or any person named by me (listed above) will not leave the premises and will remain in the waiting room for the duration of my child's therapy session.

_____ _____

Child's Name **Date of Birth**

_____ _____

Print Parent/Guardian Name **Relationship to child**

_____ _____

Signature **Date**