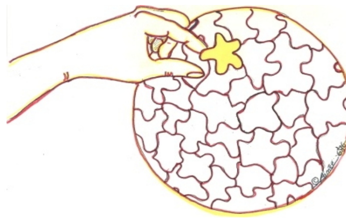

HONORED SPACES PSYCHOTHERAPY

PERSONAL HISTORY –ADOLESCENTS

Client’s name:____ Today's Date: ___/___ /___

Gender: ___ F ___ M Date of birth: __ _/___ / ___ Age: _____Grade in school: ________

Form completed by (if someone other than client): ______________________________________

Address: City: State: Zip:

____

____

Email Address:____

Phone (home):_________________(cell phone)________________(work):__________Ext:____Permission to leave messages at the following? Work_____email_____voicemail_____Phone/text_______

Emergency contact name: Phone:____

*If more space for any of the following questions is needed, please use the back of the sheet. *

Primary reason(s) for seeking services:

Anger management_______Anxiety_________ Coping_________ Depression _________

Eating disorder_____Fear/phobias_______Mental confusion________ Sexual concerns_______

Sleeping problems______Addictive behaviors______Alcohol/drugs______ Hyperactivity_____

Other mental health concerns (specify):

____

____

Family History:

With whom does the child live at this time? Natural Parents_______ Step Parents____________ Adoptive Parents_________Relative___________Foster Home________ or Other (specify)____

Are parents 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 which might be beneficial in counseling? Yes _______No_______ If Yes, describe:____

Client's Mother:

Name: ____Age: _______Employed?__________

Place of Employment:_______________________________Work phone: __________EXT____

Mother's education: ____

As the child's mother, describe your manner of discipline:____

____

For what reasons do you discipline?

____

____

Client's Father:

Name: ________________________________Age:_________ Occupation: ________________

Where employed: _________________________________Work phone: __________________

Father's education:____

Is there anything notable, unusual or stressful about the child's relationship with the child's father? ________ 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:

Name of sibling	Age	Gender	Lives	Quality of Relationship w/client
		M/F	Home Away	Poor Average Good

Please list the same for others living in Relationship the household (example: grandparents, cousin, foster child)

____
____
____

Family 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:

Allergies__________ Deafness_________ Muscular Dystrophy __________ Anemia_________

Diabetes__________Nervousness______ Asthma_______ Glandular problems _____

Perceptual motor disorder ________Bleeding tendency _______Heart diseases_____ Mental Retardation (Developmental Delay)_______Learning Disabilities_____________

Blindness ______High blood pressure______ Seizures______ Cancer_____Kidney disease____

Spinal Bifida_____ Cerebral Palsy_____ Mental illness_____ Suicide______ Cleft lips_____

Cleft palate ________Migraines ______Multiple sclerosis_______ Other (specify): ________

____

Comments About Family Health:

____

____

Childhood/Adolescent History

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 was number __________of total children.

While pregnant did the mother smoke? __________If Yes, what amount: __________________

Did the mother use drugs of alcohol_______ 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: ______________________

____

____

Describe any complications for the mother or the baby after the birth: _____________________

____

Infancy/Toddlerhood Check all which apply:

Breast fed_______ Milk allergies_________ Vomiting_________ Diarrhea_________

Bottle fed________ Rashes_________ Colic________ Constipation__________

Not cuddly__________ Liked to cuddle_______ Clingy___________Cried often_________

Rarely cried_______ Overactive ________Resisted solid food________ Trouble sleeping______

Irritable when awakened_______Lethargic__________

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: __________ (Continued)

Spoke sentences:_________ Toilet trained: ___________

Weaned:_________ Dry during day: ______________

Fed self: __________Dry during night: _____________

Compared with others in the family, child's development was: slow ____average ____fast _____

Age for following occurrences (fill in where applicable)

Began puberty:________ Menstruation: ______________

Voice change:__________ Breast development: __________

Injuries or hospitalization:____

____

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

____

____

____

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 your child are spiritual matters? Not____ Little_____ Moderate____ Much___

Is your child affiliated with a spiritual or religious group? Yes_____ No_______

If Yes, describe:____

Is your family affiliated with a spiritual or religious group? Yes ______No________

If Yes, describe:____

Education

Current school: ________________________________School phone number: ______________

Type of school: Public________ Private _________Home schooled_____ Other (specify): ____

____

Grade: ______Teacher: _________

School Counselor(if applicable):____

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: ____

Check the descriptions which 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):

____

____

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.)

Activities	How often now	How often in the past?

____

____

____

____

Medical/Physical Health

Abortion _______	Hay-fever ________	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:____

____

List any recent health or physical changes: ____

____

Please check if there have been any recent changes in the following:

Sleep patterns ______Eating patterns ________Behavior ______Energy level ________

Physical activity level______ General disposition ______Weight gain______ Wt. Loss______
Nervousness/tension_____

Describe changes in areas in which you checked above:

____
____
____

Most recent examinations Date Reason Results

Last physical exam ____________Last doctor's visit ____________

Last vision exam _____________Dental exam______________

Last hearing exam __________Most recent surgery _________

Other surgery ____

Upcoming surgery ____

Family history of medical problems:____

Medications

Current prescribed and over-the-counter medications

Dose ____________ how many times/day ________ Purpose ____________________ Side effects

____
____
____
____
____
____

____

Allergic to any medications or drugs? Yes ______No ______

If Yes,
describe:____

Nutrition

Meals: How often__________________ Typical foods eaten_____________ Typical amount eaten_______(average, a lot, a little)

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? Yes______No______

If Yes, describe & complete information below: ____

____

Method of last use and amount	Frequency of use	Age of first use	Age of last use	Used in 48 hrs Y- No	last Used in 30 days Y - No

Alcohol____

Barbiturates ____

Valium/Librium ____

Cocaine/Crack____

Heroin/Opiates ____

Marijuana Page ____

PCP/LSD/Mescaline____

Inhalants ____

Caffeine ____

Nicotine

____

Over the counter ____

Prescription drugs ____

Other drugs ____

Substance of preference ____

Substance Abuse Questions to be answered by Child/Adolescent

Describe when and where you typically use substances: ___________________________________

____

Describe any changes in your use patterns: ____

____

Describe how your use has affected family or friends (include their perceptions of your use):____

____

____

Reason(s) for use:

Addicted_____ Build confidence ______Escape_____ Self-medication______

Socialization_____ Taste _____Other____ (specify):______________________________________

How do you believe your substance use affects your life?

____

Who or what has helped you in stopping or limiting your use?

____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol? _____

If Yes, describe:____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ________

If Yes, describe:____

Have you had adverse reactions or overdose to drugs or alcohol? (describe):

____

____

Parents Counseling/Prior Treatment History____

____

Information about child/adolescent (past and present):

	Yes	No	When	Where	Child/Adolescent's reaction

Counseling/Psychiatric treatment____

Suicidal thoughts/attempts ____

Drug/alcohol treatment____

Hospitalizations____

Involvement with self-help

groups (e.g., AA, Al-Anon,

NA, Overeaters Anonymous) ____

Information about family/significant others (past and present):

Counseling/Psychiatric_TX____

Suicidal thoughts/attempts ____

Drug/alcohol treatment____

Hospitalizations____

Involvement with self-help

groups (e.g., AA, Al-Anon,_

NA, Overeaters Anonymous)____

Behavioral/Emotional

(Please check any of the following that are typical for your child)

Affectionate_____Frustrated _____easily sad________

Aggressive_________Gambling_________Selfish_________

Alcohol problems_______Generous________Separation anxiety________

Angry________Hallucinations_______Sets fires________(continued on next page)

Anxiety________Head banging________Sexual addiction_______Sexual acting out_______

_Attachment to dolls_______ Avoids adults________Hopelessness_______Shares______

Bedwetting_____Hurts animals______Sick often______ Short attention span__________

Blinking_____jerking movements________Imaginary friends_______Bizarre behavior_____

Impulsive______ Shy______ timid ______Bullies______ threatens_____ Irritable _____

Sleeping problems _______Careless_______ reckless_______ Lazy ______Slow moving_____

Chest pains ________Learning problems_______ Soiling(toilet accidents)_____

Clumsy______ Lies frequently_______ Speech problems_______

Confident______ Listens to reason_______ Steals______

Cooperative ________Loner _______Stomach aches _______

Cyber addiction______ Low self-esteem______ Suicidal threats _______

Defiant________ Messy______ Suicidal attempts _______

Depression_______ Moody______ Talks back______

Destructive_______ Nightmares_______ Teeth grinding_______

Difficulty speaking_____ Obedient ____Thumb sucking________

Dizziness_____ Often sick_______ Tics or twitching______

Drug addiction______ Oppositional ________Unsafe behaviors________

Eating disorder_________ Over active_______ Unusual thinking ______

Enthusiastic_____ Overweight _______Weight loss__________

Excessive masturbation________ Panic attacks ______Withdrawn ________

Expects failure______ Phobias ______Worries excessively_______

Fatigue______ Poor appetite_______ Other________

Fearful ________Psychiatric problems_______

Frequent injuries_________ Quarrels ________

If need-be, please describe any of the above (or other) concerns:

____

____

____

How are your child's problematic 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:____

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, if any, would you like to see in the therapy?

____

____

Do you believe the child is suicidal at this time? Yes_____ No _____If Yes, explain:

____

____

By signing below, I am stating that I am willingly bringing my child in for evaluation and counseling.

Parents signature:____ Date: / /