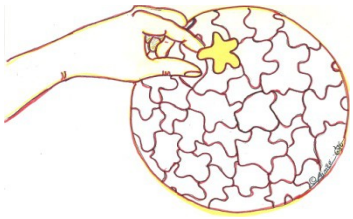

HONORED SPACES PSYCHOTHERAPY

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:

_____

_____

__

Phone (home):_____(cell phone)_____(work):_____Ext:____

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 M/F	Lives Home Away	Quality of Relationship w/client Poor Average Good

_____

_____
_____
_____
_____
____

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

Relationship

_____
_____
_____
___

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 last 48 hrs Y- No	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: / /