



HONORED SPACES PSYCHOTHERAPY

PERSONAL HISTORY – CHILDREN (through age 12)

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: _____

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For what reasons do you discipline? _____

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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: _____

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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.)

<u>Activities</u>	<u>How often now</u>	<u>How often in the past?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

<u>Dose</u>	<u>how many times/day</u>	<u>Purpose</u>	<u>Side effects</u>
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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)

Information about child/adolescent (past and present):

	Yes	No	When	Where	Child/Adolescent's reaction
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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: / /