

**CHILD AND FAMILY COUNSELING CENTER
CHILD AND ADOLESCENT HISTORY FORM**

IDENTIFYING INFORMATION:

PATIENT NAME: _____ DATE OF BIRTH: _____

DATE FORM COMPLETED: _____

NAME OF PERSON COMPLETING FORM: _____

SCHOOL: _____ GRADE: _____

REASON FOR SEEKING TREATMENT: _____

DURATION OF PROBLEM: 1 mo. 1-3 mos. 3-6 mos. 6-12 mos. 1-2 yrs. 2-5 yrs. 5-10 yrs. 10+yrs.

CURRENT THERAPY? YES NO

If yes, please provide the name of your child's therapist:

IS YOUR CHILD CURRENTLY TAKING PSYCHIATRIC MEDICATION? YES NO

If yes, please give the name of the prescriber and list the medications your child is taking (and dosages):

PRIOR THERAPY? YES NO BRIEF LONG TERM REPEATED DAY TX. INPATIENT
PARTIAL HOSPITALIZATION IOP HELPFUL UNHELPFUL NOT SURE

NAMES OF PREVIOUS THERAPISTS: _____

NAMES OF PREVIOUS PSYCHIATRISTS: _____

FAMILY DATA:

IS THE FAMILY INTACT? YES NO

PARENTAL STATUS: NEVER MARRIED MARRIED SEPARATED DIVORCED

WHO LIVES IN THE HOME?

ADULTS: .

<i>NAME</i>	<i>AGE</i>	<i>RELATIONSHIP</i>
1. _____		
2. _____		
3. _____		
4. _____		

CHILDREN IN THE HOME (List name and ages)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

MOTHER'S INFORMATION:

OCCUPATION:
HEALTH STATUS:

LEVEL OF EDUCATION:
HISTORY OF PSYCHIATRIC PROBLEMS: YES NO

FATHER'S INFORMATION:

OCCUPATION:
HEALTH STATUS:

LEVEL OF EDUCATION:
HISTORY OF PSYCHIATRIC PROBLEMS: YES NO

LANGUAGE(S) SPOKEN IN HOME (IF OTHER THAN ENGLISH): _____

PATIENT'S USUAL CHORES IN THE HOME: _____

HOW COOPERATIVE IS CHILD WITH DOING CHORES? COOPERATIVE RESISTANT REFUSES

HOW DOES THE PATIENT GET MONEY? WHEN? HOW MUCH? _____

ANY PETS AT HOME? NO YES DOES YOUR CHILD HELP CARE FOR THE PETS? YES NO SOMETIMES

WHAT ACTIVITIES DOES THE FAMILY DO TOGETHER? _____

HOW DOES THIS CHILD RELATE TO HIS OR HER SIBLINGS? _____

HOW OFTEN DOES THE FAMILY EAT DINNER TOGETHER? _____

HOW MUCH TIME DOES YOUR CHILD SPEND PLAYING VIDEO GAMES? _____

HOW MUCH TIME DOES YOUR CHILD SPEND ONLINE? _____

DO YOU MONITOR YOUR CHILD'S ONLINE ACTIVITIES? YES NO SOMETIMES

HAS THE FAMILY MOVED? YES NO IF YES, DESCRIBE MOVES BELOW:
WHEN WHERE WHY

1.

2.

3.

4.

DOES THE PATIENT HAVE CLOSE CONTACT WITH EXTENDED FAMILY? YES NO

DOES THE FAMILY PRACTICE A RELIGION? YES NO WHICH FAITH? _____

FAMILY PSYCHIATRIC AND SUBSTANCE ABUSE HISTORY

IS THERE ANY HISTORY OF VIOLENCE IN THE FAMILY? YES NO

IS THERE ANY HISTORY OF SUICIDE IN THE FAMILY? YES NO

IS THERE ANY HISTORY OF ALCOHOL OR DRUG PROBLEMS IN THE FAMILY? YES NO

IS THERE ANY HISTORY OF PSYCHIATRIC PROBLEMS IN THE FAMILY, E.G. DEPRESSION, ANXIETY, BIPOLAR DISORDER, SCHIZOPHRENIA, AUTISM, ADHD, ETC.? YES NO

IF YES, DESCRIBE: _____

HAVE THERE BEEN ANY TRAUMATIC EVENTS IN THIS CHILD'S LIFE? YES NO

IF YES, EXPLAIN: _____

BLENDED, SEPARATED, OR DIVORCED FAMILIES PLEASE COMPLETE THIS SECTION

WHEN DID THE DIVORCE OR SEPARATION OCCUR?

WHO IS THE CUSTODIAL PARENT? _____ IS CUSTODY JOINT? YES NO

WHERE IS THE NON-CUSTODIAL PARENT? _____

HOW OFTEN DOES THE CHILD SEE HIS OR HER NON-CUSTODIAL PARENT? _____

MOTHER'S MARITAL HISTORY:

DATES MARRIED _____ SPOUSE'S NAME _____

- 1. _____
- 2. _____
- 3. _____

FATHER'S MARITAL HISTORY:

DATES MARRIED _____ SPOUSE'S NAME _____

- 1. _____
- 2. _____
- 3. _____

IF NOT REMARRIED:

DOES YOUR CHILD'S MOTHER HAVE A SIGNIFICANT OTHER? YES NO
NAME: _____ HOW LONG? _____

DOES YOUR CHILD'S FATHER HAVE A SIGNIFICANT OTHER? YES NO
NAME: _____ HOW LONG? _____

DEVELOPMENTAL AND HEALTH HISTORY

NAME OF PRIMARY CARE PHYSICIAN: _____

ADDRESS/PHONE: _____

DATE OF LAST PHYSICAL? _____

PLANNED PREGNANCY? YES NO ADOPTED? YES NO AGE WHEN ADOPTED: _____

WERE THERE ANY PROBLEMS DURING THE PREGNANCY, SUCH AS TOXEMIA, DIABETES, HIGH BLOOD PRESSURE, OTHER? YES NO
IF YES, DESCRIBE: _____

DID MOTHER USE MEDICATIONS, ALCOHOL, OR DRUGS DURING PREGNANCY? YES NO
IF SO, WHICH ONES? _____

WERE THERE ANY PROBLEMS DURING DELIVERY? YES NO
IF YES, DESCRIBE: _____

FORCEPS USED? YES NO OXYGEN USED? YES NO

BIRTH WEIGHT: _____ APGAR SCORE IF KNOWN: _____

WERE THERE ANY PROBLEMS DURING YOUR CHILD'S FIRST 3 MONTHS WITH THE FOLLOWING:

BREATHING? YES NO FEEDING? YES NO COLICKY? YES NO

SLEEPING? YES NO

WHO WERE THE PRIMARY CARETAKER(S) DURING THESE PERIODS OF TIME?

1 - 3 MONTHS: _____

3 - 6 MONTHS: _____

6 - 12 MONTHS: _____

12 - 24 MONTHS: _____

24 - 36 MONTHS: _____

36 - 48 MONTHS: _____

DID YOUR CHILD ATTAIN DEVELOPMENTAL MILESTONES AT EXPECTED AGES? (CIRCLE "NORMAL" IF NORMAL; IF ABNORMAL, CIRCLE "NO" AND EXPLAIN):

EATING: NORMAL NO _____

SLEEPING: NORMAL NO _____

TOILET NORMAL NO _____
TRAINING:

WALKING: NORMAL NO _____

TALKING: NORMAL NO _____

GROSS NORMAL NO _____
MOTOR:

FINE NORMAL NO _____
MOTOR:

(**Gross motor:** throwing, hopping, running; **Fine motor:** writing, coloring, tying, use of scissors)

ANY PARTICULAR TALENTS? (E.G. MUSIC, ARTS, ATHLETIC) _____

RIGHT OR LEFT HANDED? RIGHT LEFT AMBIDEXTROUS

ANY PHYSICAL OR INTELLECTUAL HANDICAPS? YES NO
IF YES, DESCRIBE:

ANY REGULAR MEDICATIONS? YES NO

LIST ANY MEDICATIONS (NON PSYCHIATRIC) AND DOSAGES IF KNOWN: _____

DOES THE CHILD TAKE ANY VITAMINS OR OTHER SUPPLEMENTS? YES NO
IF YES, WHICH ONES? _____

DOES CHILD HAVE HISTORY OF EAR INFECTIONS? YES NO

HAS YOUR CHILD HAS BEEN HOSPITALIZED FOR PHYSICAL OR EMOTIONAL PROBLEMS? YES NO
IF YES, DESCRIBE WHEN AND WHY: _____

DOES YOUR CHILD WEAR GLASSES? YES NO NEARSIGHTED FARSIGHTED ASTIGMATISM

ANY HISTORY OF ALLERGIES, INCLUDING ALLERGIES TO MEDICATIONS: YES NO
IF YES, DESCRIBE: _____

HAS YOUR CHILD EVER HAD A SERIOUS MEDICAL PROBLEM? YES NO
IF YES, EXPLAIN _____

IS THERE ANY HISTORY OF: LEAD POISONING FRACTURES, OR SEIZURES?

ANY HISTORY OF HEAD INJURIES, LOSS OF CONSCIOUSNESS, OR BLOWS TO THE HEAD? YES NO
IF YES, DESCRIBE: _____

ANY PROBLEMS WITH BEDWETTING? YES NO SOILING? YES NO

ANY PROBLEMS WITH MEMORY? YES NO

HOW MUCH EXERCISE DOES YOUR CHILD GET ON A DAILY BASIS? _____

DOES YOU CHILD EAT A WELL-BALANCED DIET? YES NO PICKY EATER? YES NO

DESCRIBE ANY PROBLEMS WITH DIET: _____

ACADEMIC HISTORY:

CURRENT GRADES: FAILING BELOW AVERAGE AVERAGE ABOVE AVERAGE
EXCELLENT VARIABLE

SCHOOL BEHAVIOR: APPROPRIATE INAPPROPRIATE
DESCRIBE ANY PROBLEMS:

ATTENDANCE: GOOD FAIR POOR

GRADES: AVERAGE BELOW AVERAGE ABOVE AVERAGE VARIABLE

HAS CHILD EVER BEEN SUSPENDED OR EXPELLED FROM SCHOOL? YES NO
IF SO, WHEN AND WHY?

RELATIONSHIP WITH TEACHER(S): EXCELLENT AVERAGE POOR

RELATIONSHIP WITH PEERS: EXCELLENT AVERAGE POOR

DOES YOUR CHILD HAVE CLOSE FRIENDS? YES NO

HOW IS YOUR CHILD'S SCHOOL BEHAVIOR?:

GOOD FAIR POOR DISRUPTIVE DEFIANT INVOLVED IN FIGHTS

HAS CHILD EVER HAD EDUCATIONAL OR PSYCHOLOGICAL TESTING? YES NO

IF SO, WHEN? RESULTS? (PLEASE PROVIDE COPIES OF REPORTS IF YOU HAVE THEM)

HAS YOUR CHILD EVER HAD SPECIAL PLACEMENTS IN SCHOOL? (eg. IEP, CHILD STUDY, OR 504 PLAN) YES NO

IF YES, PLEASE DESCRIBE: _____

IS CHILD CURRENTLY RECEIVING ANY SERVICES AT SCHOOL? YES NO

IF YES, WHAT SERVICES? _____

HAS CHILD EVER REPEATED A GRADE? YES NO IF YES, WHICH? _____

DOES CHILD PARTICIPATE IN ANY SCHOOL ACTIVITIES? YES NO

WHICH ACTIVITIES? _____

ARE YOU SATISFIED WITH CHILD'S CURRENT SCHOOL PLACEMENT? YES NO

IF NO, PLEASE EXPLAIN: _____

BEHAVIOR AND TEMPERMENT

DESCRIBE YOUR CHILD'S USUAL BEHAVIORS: _____

DESCRIBE YOUR CHILD'S USUAL MOOD AND TEMPERAMENT: _____

DOES HE/SHE HAVE A GROUP OF CLOSE FRIENDS? YES NO

HOW DOES HE/SHE RELATE TO AUTHORITY? GOOD FAIR POOR DEFIANT

HAS YOUR CHILD EVER VOICED ANY SUICIDAL THOUGHTS? YES NO

IF YES, EXPLAIN: _____

HAS YOUR CHILD EVER ATTEMPTED SUICIDE? YES NO IF YES, EXPLAIN: _____

ADOLESCENT ISSUES (12-18 YEARS OLD)

FOR GIRLS, HAVE MENSES BEGUN? NO YES WHEN?

DOES HE/SHE DATE? YES NO

DOES HE/SHE HAVE A STEADY GIRLFRIEND/BOYFRIEND? YES NO

IS HE/SHE SEXUALLY ACTIVE? YES NO DON'T KNOW

IF YES, HAS HE/SHE BEEN TESTED FOR STD'S? YES NO

HAS SHE EVER BEEN PREGNANT? YES NO (IF YES, OUTCOME?) _____

DOES HE/SHE DRIVE? YES NO PERMIT LICENSE

DOES HE/SHE HAVE A JOB? YES NO IF YES, WHERE? _____

NUMBER OF HOURS PER WEEK: _____

PLANS POST-HIGH SCHOOL: _____

DOES HE/SHE USE ALCOHOL? YES NO DON'T KNOW

DOES HE/SHE USE TOBACCO OR SMOKE CIGARETTES? YES NO DON'T KNOW

DOES HE/SHE VAPE? YES NO DON'T KNOW

DOES HE/SHE USE MARIJUANA? YES NO DON'T KNOW

DOES HE/SHE USE OTHER DRUGS? YES NO DON'T KNOW

PLEASE NOTE ANY CONCERNS YOU HAVE ABOUT YOUR CHILD'S DRUG OR ALCOHOL USE:

HAS HE/SHE EVER RUN AWAY FROM HOME? YES NO

HAS HE/SHE EVER HAD LEGAL PROBLEMS? YES NO

IS CHILD ON PROBATION OR HAVE A COURT DATE COMING UP? YES NO

IF YES, EXPLAIN:

IS THERE ANY OTHER INFORMATION YOU WISH TO PROVIDE? _____

(Updated 2-3-26)