Personal History Form- Child and Adolescent

Child's Name _____ Todays Date _____

Date of Birth _____ Religion / Spirituality _____

Race / Ethnicity _____ Gender Identity _____

Name of person completing this form: _____ Relationship to child: _____

Does this child live with you: Yes ☐ No ☐ Do you have legal custody: Yes ☐ No ☐

If No legal custody, please explain: _____

If Yes legal custody, please list the names of any other adult who also has legal custody (e.g., another parent, whether in the home or outside of the home):

_____

Home Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Ok to leave message? Yes ☐ No ☐

Mobile Phone _____ Ok to leave message? Yes ☐ No ☐

Information for Clients

Your child's intake consists of a series of questionnaires and an interview lasting about 90 minutes. Rather than focus on a list of questions during the initial interview we prefer to focus on your child's current concerns and goals and how we can help your child. Completing this form will help with that process.

Intake Questions

Child's current living situation: Apartment/Rent ☐ Own Home ☐

If divorced parents, is child going between homes or mainly at one? _____

Please list the names, ages, and relationships of the people your child lives with.

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Please tell us about any concerns you have regarding your child's current housing situation.

_____

Is your child currently employed? Yes ☐ No ☐ Briefly describe your child's current and past employment history.

Dates of Employment	Place of Employment	Job Title	Job Duties	Any Job Problems?

Please tell us about any concerns you have regarding your child's current employment situation.

_____

Child's primary physician name and phone number:

_____

Date of child's last physical exam: _____

Please list your child's current medical diagnosis: _____

Please list any surgeries and dates: _____

List **all** medications, drugs, or other substances your child is currently taking or has taken in the last year—prescribed, over-the-counter vitamins, herbs, and others. If you have a list, you can provide a copy of the list.

Medication / Drug	Dose	How often?	Taken since (start date)	Reason to take it?	Is it effective?

Does your child have any medication or food allergies? Yes ☐ No ☐ Unsure ☐

If yes, please specify: _____

Does your child have any history of concussions / loss of consciousness? Yes ☐ No ☐ Unsure ☐

If yes, when? _____

Is this child adopted? Yes ☐ No ☐ Is this child in foster care? Yes ☐ No ☐

If this child is adopted or in foster care, from what age? _____

How old was the mother (or birth mother, in case of adoption or foster care) when she became pregnant with this child? _____

How long was the pregnancy: Full Term ☐ Other ☐ (specify): _____

Were there any problems during the mother's pregnancy with this child? Yes ☐ No ☐ Unsure ☐

If yes, please specify: _____

Is your child attending school? Yes ☐ No ☐

Name of school _____

Please briefly list information about your child's educational history.

School Name	Grade(s) Attended	Year(s) Attended	Graduated (Yes/No/Not Applicable)	Graduation Year	Any accommodations?

Best subject(s): _____ Worst subject(s): _____ Failed or repeated any grades?

SAT scores? _____ Any other known standardized test scores? _____

Has your child received special education services or other special help in school (IEP or 504 plan)? Yes ☐ No ☐

Please tell us about any concerns you have regarding school: _____

Does your child drink alcoholic beverages? Yes ☐ No ☐ Unsure ☐

If yes, how much and how often? _____

Does your child consume nicotine or tobacco? Yes ☐ No ☐ ☐

If so, please specify # of cigarettes/e-cigarettes/tobacco per day: _____

Does your child have any previous psychiatric diagnoses? Yes ☐ No ☐ Unsure ☐

If yes, please specify: _____

Has your child ever been hospitalized for any emotional or psychiatric reason? Yes ☐ No ☐ Unsure ☐

If yes, how many times has your child been hospitalized? _____

Date(s) of Treatment	Name of Hospital	Reason for Hospitalization	Dates of Stay?

Has your child ever received psychiatric or psychological treatment before (e.g. counseling)? Yes ☐ No ☐ Unsure ☐

If yes, please complete:

Date(s) of Treatment	Name of Clinician	Reason for Treatment	Dates of Stay?

Is your child taking any medication for psychiatric reasons? Yes ☐ No ☐ Unsure ☐

If yes, please complete:

Medication	Dose	Frequency	Name of Prescriber

Has your child ever made a suicide attempt? Yes ☐ No ☐ Unsure ☐

If yes, how many times? _____

Approximate Date	What method of suicide was used?	Was Your Child Hospitalized?

Has your child ever engaged in self-injurious behavior (e.g., cutting, burning, head-banging…)? Yes ☐ No ☐ Unsure ☐

If yes, how many times? _____

Approximate Dates	What Did Your Child Do To Hurt Him/Herself?	Was Your Child Hospitalized?

Place a checkmark next to each item that your child has <u>experienced prior to their 18th birthday</u>:	✓
Has your child not had enough to eat, had to wear dirty clothes, or had no one to protect or take care of them?	
Has your child lost a parent through divorce, abandonment, death, or other reason?	
Has your child lived with anyone who was depressed, mentally ill, or attempted suicide?	
Has your child lived with anyone who had a problem with drinking or using drugs, including prescription drugs?	
Have child's parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	
Has your child lived with anyone who went to jail or prison?	
Has a parent or adult in the home ever sworn at your child, insult your child, or put your child down?	
Has a parent or adult in your child's home ever hit, beat, kick, or physically hurt your child in any way?	
Has your child felt that no one in the family loved them or thought they were special?	
Has your child experienced unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	
Do you or your child believe that these experiences have affected your child's health? ***Not much*** ☐ ***Some*** ☐ ***A lot*** ☐	

Does your child have access to firearms? Yes ☐ No ☐ Unsure ☐

Does your child have distress related to gender identity? Yes ☐ No ☐ Unsure ☐

Does your child have any criminal history, including arrests and penalties, or is your child currently involved in any legal actions? Yes ☐ No ☐ Unsure ☐

Has anyone in your family ever made a suicide attempt? Yes ☐ No ☐ Unsure ☐

If so, how is this person related to your child? _____

Has anyone in your family died from suicide? Yes ☐ No ☐ Unsure ☐

If so, how is this person related to your child? _____

Does anyone in your family have a history of mental illness, alcohol abuse, drug abuse, or other addictions? Yes ☐ No ☐ Unsure ☐

If so, how are these people related to your child, and what is a summary of their problems?

_____

_____

_____

Scheduling Preferences

Services Requested (check all that apply): Individual ☐ Family ☐ Group ☐

Please provide your child's availability for appointments below:

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Other Information

Is there any other information that you would like to share about your child?