



# Confidential Child/Adolescent History

## PARENT/GUARDIAN COMPLETES THIS SECTION

Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

**Child/Adolescent's Name:** \_\_\_\_\_ Name preferred: \_\_\_\_\_

Sex:  Male  Female Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell Phone : \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ May we contact client's mother?  Yes  No

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ May we send mail here:  Yes  No

Home Phone: \_\_\_\_\_ May we leave a message here:  Yes  No

Cell Phone: \_\_\_\_\_ May we leave a message here:  Yes  No

Work Phone: \_\_\_\_\_ May we leave a message here:  Yes  No

Email Address: \_\_\_\_\_ May we send a message here:  Yes  No

**Father's Name:** \_\_\_\_\_ May we contact client's father ?  Yes  No

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ May we send mail here:  Yes  No

Home Phone: \_\_\_\_\_ May we leave a message here:  Yes  No

Cell Phone: \_\_\_\_\_ May we leave a message here:  Yes  No

Work Phone: \_\_\_\_\_ May we leave a message here:  Yes  No

Email Address: \_\_\_\_\_ May we send a message here:  Yes  No

**Emergency Contact** (other than parent/guardian): \_\_\_\_\_

**Primary Custodial Parent or Guardian:** \_\_\_\_\_

Relationship to Child/Adolescent: \_\_\_\_\_ Phone: \_\_\_\_\_

**RELATIONAL INFORMATION**

Current Marital Status:  Single  Engaged  Married  Separated  Divorced  Widowed

Are you content with your current status?  Yes  No

If no, briefly explain: \_\_\_\_\_

If married, how long? \_\_\_\_\_ # of marriages for you: \_\_\_\_\_ For spouse: \_\_\_\_\_

If separated or divorced, how long? \_\_\_\_\_ If widowed, how long? \_\_\_\_\_

With whom does child/adolescent currently live? (Check all that apply):

Alone  Parent(s)  Sibling(s)  Grandparents  Friend  Other: \_\_\_\_\_

Do you have a personal support system?  Yes  No If yes, who? \_\_\_\_\_

**If you live with a partner, please provide the following information.**

Partner's Name: \_\_\_\_\_ Sex:  Male  Female

How long have you known your partner? \_\_\_\_\_ Age: \_\_\_\_\_

What words would you use to describe this person: \_\_\_\_\_

**Children:** List your children (living or deceased) as well as children you have placed for adoption.

(Use back if necessary.)

Name	Sex	Age or Year of Death	Relationship to you (e.g., Biological, step, adopted)	Living with you?	Describe him/her

Have you ever had a miscarriage or medical abortion?  Yes  No

If yes, when? \_\_\_\_\_

**RELIGIOUS BACKGROUND**

Briefly describe the religious environment of your home as you were growing up:

\_\_\_\_\_

\_\_\_\_\_

Do you regularly attend a place of worship?  Yes  No If yes, where?

\_\_\_\_\_

**PRESENTING ISSUES AND GOALS**

What has led you to seek counseling for your child/adolescent at this time?

\_\_\_\_\_

\_\_\_\_\_

What specific goals do you hope your child/adolescent will achieve during the counseling experience? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PREVIOUS COUNSELING**

Has your child/adolescent seen a counselor previously? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, where? \_\_\_\_\_

**CURRENT STATUS**

**Please check any of the following physiological symptoms that apply to your child/adolescent**

- Headaches
- Vision Problems
- Difficulty breathing
- Change in Appetite
- Hearing voices
- Dizziness
- Sleep Trouble
- Tension
- Intestinal Trouble
- Tiredness
- Seeing Things
- Stomach Trouble
- Trouble Relaxing
- Rapid Heart Rate
- Hearing Noises
- Pain
- Other

Has there been any weight change in the last 2-3 months? (If so, how?)

\_\_\_\_\_

**Behavioral Checklist**

- Oppositional/Defiant
- Wetting the bed
- Soiling pants during day
- Acting out sexually
- Setting fires
- Cruelty to animals
- Clingy
- Tired/Lethargic
- Aggressiveness
- Impulsive Behavior
- Anxiety
- Drug Use
- Whiney
- Somatic complaints
- Fearful of people
- Fearful of places
- Fearful of being alone
- Tobacco
- Overly concerned with appearance
- Low Self-esteem
- Temper
- Compulsivity
- Depression
- Sleep disturbance
- Stealing
- Lying
- Cries easily
- Academic problems
- Trouble with siblings
- Trouble with peers
- Alcohol
- Changes in eating
- Anger
- Loss of Self-Control

**Additional**

- Divorce
- Stress
- Trauma
- Recent Death
- Grief
- Unhappiness
- Loneliness
- Hopelessness
- Fears
- Guilt
- Legal Matters
- Foster Care/Group Homes
- Verbal abuse
- Emotional Abuse
- Physical Abuse
- Sexual Abuse
- Pregnancy
- Abortion
- Sexual Problems
- Concentration
- Memory
- Making decisions
- Serious Illness
- Friends
- Racing Thoughts
- Communication
- Unwanted Thoughts
- Panic
- Inferior Feelings
- Shyness
- Nervousness
- Bad Dreams
- Frequent moves
- Adoption
- Step-family
- Parental loss of job
- Drug/Alcohol addiction of family member

On the scale below, please check the severity of the child’s problem:

\_\_\_\_\_ Mild    \_\_\_\_\_ Moderate    \_\_\_\_\_ Severe    \_\_\_\_\_ Incapacitating

**Education**

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Has your child / adolescent ever had any disciplinary problems in school?  Yes  No

If yes, please describe:

\_\_\_\_\_

How do you rate your child/adolescent’s school experience on a scale of 1-5 where 1 is extremely negative and 5 is extremely positive?

- 1     2     3     4     5
- Negative    Average    Positive

**Legal History / Social Agency Involvement**

Has your child / adolescent been involved with the justice system? (e.g., arrest, detention, court, etc.)

Yes  No If yes, please describe:

Has the child/adolescent ever had any involvement with the Department of Families & Protective Services or a similar agency in Texas or another state?  Yes  No

If yes, please describe: \_\_\_\_\_

**MEDICAL INFORMATION**

Primary Physician: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Specialty (e.g. Family Practice, OB/GYN, Internal Medicine): \_\_\_\_\_

Is your child / adolescent currently receiving medical treatment?  Yes  No

If yes, please specify: \_\_\_\_\_

List significant conditions, illnesses, surgeries, hospitalizations, traumas, or treatments you've had. (Use back if necessary.)

List all current medications you are taking, including those you seldom use or take only as needed. (Use back if necessary.)

Medication	Dosage	Purpose for Medication	Taking as prescribed

Has a physician ever recommended any anti-anxiety, anti-depressant, ADHD, or anti-psychotic medication for your child/adolescent?  Yes  No

If yes, please describe: \_\_\_\_\_

What diagnosis was your child given? \_\_\_\_\_

Has anyone in your child/adolescent's family ever been treated or hospitalized for mental health issues, substance abuse, or psychiatric conditions?  Yes  No

If yes, please describe: \_\_\_\_\_

Has your child/adolescent ever been abused or experienced a trauma?  Yes  No

If yes, please describe: \_\_\_\_\_

I \_\_\_\_\_ (Parent/Legal Guardian), certify that the above information is true and complete. My signature below acknowledges that I have completed this information to the best of my knowledge and I have read and understand the conditions, statements, and authorizations disclosed.

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
Date

# CHILD / ADOLESCENT COMPLETE THIS SECTION

Why do you think you are coming here today?

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What specific goals do you hope to achieve during the counseling experience?

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Please list your strengths:

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## FAMILY HISTORY

How would you describe your relationship with your mother?

Excellent  Good  Fair  Poor

How would you describe your relationship with your father?

Excellent  Good  Fair  Poor

Do you have stepparents?  Yes  No

If yes, how would you describe your relationship with your stepparents?

Excellent  Good  Fair  Poor

Do you have siblings?  Yes  No

If yes, how would you describe your relationship with your siblings?

Excellent  Good  Fair  Poor

## EDUCATION

How would you rate your school experience on a scale of 1-5 where 1 is extremely negative and 5 is extremely positive?

1     2     3     4     5  
Negative                  Average                  Positive

## SUBSTANCE USAGE

*I would prefer to discuss this with the counselor in person.*

Which of the following have you tried or used?

Wine  Liquor  Beer  Tobacco  Marijuana  LSD/Heroin

Cocaine  Speed  Ecstasy  Downers  PCP  Prescription Drugs

Acid  Cigarettes  OTC Medicine  Other: \_\_\_\_\_

At what age did you first use? \_\_\_\_\_

Have you ever used drugs before or during school?  Yes  No

Have you ever missed school or been truant because of substance use?  Yes  No

Do you ever feel pressure to use?  Yes  No

If you use alcohol or drugs, how often do you use them?  Everyday  2+ per week

Weekends  Once/Twice a month  Once a year  Holidays  Other: \_\_\_\_\_

**ABUSE / TRAUMA HISTORY**

*I would prefer to discuss this with the counselor in person.*

Have you ever been abused?  Yes  No

If yes, please describe: \_\_\_\_\_

Have you ever been sexually abused?  Yes  No If yes, please describe:

\_\_\_\_\_

Have you ever been emotionally or mentally abused?  Yes  No If yes, please describe:

\_\_\_\_\_

Have you ever experienced any other severe trauma?  Yes  No If yes, please describe:

**LEVEL OF STRESS**

Indicate how distressed you are by placing an "X" on the scale below (*1= Very Little Distress; 10=Extreme Distress*):

\_\_\_\_\_

1      2      3      4      5      6      7      8      9      10

Are you currently experiencing any suicidal thoughts?  Yes  No

Have you experienced them in the past?  Yes  No

Have you ever attempted suicide?  Yes  No

If yes, when and how? \_\_\_\_\_

Have any of your friends or family ever committed or attempted suicide?  Yes  No

Who is part of your support system?  
\_\_\_\_\_  
If you feel like hurting yourself, who would you tell?  
\_\_\_\_\_

**MENTAL STATUS**

How would you describe yourself: *Check all that apply*

Happy  Sad  Afraid  Lonely  Hurt  Angry

Other: \_\_\_\_\_

Do you see or hear things others do not?  Yes  No

Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I \_\_\_\_\_ (Client—Child/Adolescent), certify that the above information is true and complete and that I have completed this information to the best of my knowledge.

\_\_\_\_\_  
Signature of client (Child/Adolescent)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of client (Please Print)

\_\_\_\_\_  
Date