Rush CREEK COUNSELING CENTER

# 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
□ Pornography
□ Gambling
□ Eating Disorder
□ Gaming/Technology Addiction

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?

_____

_____

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

_____

_____

Please list your strengths:

_____

_____

**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/Heroine

☐ 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: _____

**BEHAVIORAL AND ONLINE INFORMATION**

Have you... *check all that apply*

□ Had exposure to pornography?
□ Gambled online or with peers?
□ Experienced an eating disorder?
At what age was your first experience? _____

How many hours per day for the following:
□ Gaming _____
□ Social Media _____
□ Technology Devices (phones, tablet, computer, TV, etc.) _____
□ Online _____

For the above items, what do you primarily use them for?_____

_____

What apps do you primarily use or have used? _____

_____

**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