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

X