

CHILD AND ADOLESCENT PERSONAL HISTORY FORM

MENTAL HEALTH SUBSTANCE ABUSE BOTH CLIENT ID # _____

FORM COMPLETED BY (Must be over 18 years of age) _____ Relation _____

A) What brought child to treatment: _____

B) What are your expectations for treatment _____

C) Prior treatment experiences (Dates and Location _____

D) Name of Primary Care Physician: _____ Phone _____

E) Current Living Arrangements:

1. House Group Living Apartment Other (Specify) _____
2. Alone With Family Unrelated Significant Other

I. CLIENT INFORMATION (past and present)

1) Treatment Experiences Yes No Inpat./Outpt/ IOP When Where

1) <u>Treatment Experiences</u>	Yes	No	Inpat./Outpt/ IOP	When	Where
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Involvement with self-help groups (e.g. AA, Al-Anon, Overeaters Anonymous)					

2) Presenting Problem (Check all boxes that apply)

- | | |
|--|--|
| <input type="checkbox"/> Medical/Organic condition | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Aggressive Behavior |
| <input type="checkbox"/> Mania | <input type="checkbox"/> Suicidal Ideation's |
| <input type="checkbox"/> Chemical Abuse/Dependency | <input type="checkbox"/> Self-destructive Behavior |
| <input type="checkbox"/> Delusions/Hallucinations | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Family Issues | <input type="checkbox"/> Life Decision |
| <input type="checkbox"/> Relationship Issues | <input type="checkbox"/> Uncertain |
| <input type="checkbox"/> Other (please elaborate) | |

II. INFORMATION ABOUT FAMILY / SIGNIFICANT OTHERS; past and present

1. Family Constellation

	NAME	CURRENT AGE	CURRENTLY LIVING		CURRENTLY LIVING WITH YOU	
			YES	NO	YES	NO
Client						
Mother						
Father						
Significant Other						
Children						
Significant Others: (Brothers, Sisters, Grandparents, Step-relatives, Half-relatives) <i>Specify Relationship</i>						

2) FAMILY/EXTENDED FAMILY HISTORY

	Yes	No	Inpt/Outpt/IOP	When	Where
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Involvement with self-help groups					

3) Family History

1. What City/State was child born? _____
2. Where did child grow-up? _____
3. Who raised child? _____

4) Parental Information

- Parents legally married
- Parents ever separated
- Parents ever divorced
- Mother remarried (number of times) _____
- Father remarried (number of times) _____

Describe relationships with parents, step-parents

5) SIBLING INFORMATION

Number of living siblings/step siblings _____ Number of deceased siblings/step-siblings _____

What position are you in the order of siblings (oldest, 2nd, 3rd, youngest, etc.) _____

Describe relationships with siblings:

Family will be involved in treatment

Family uninformed

Why/Why Not: _____

III. CHILD'S HISTORY:

Pregnancy: Planned: Yes No Length of pregnancy: _____

Mother's weight gain: _____

While pregnant, did you smoke: Yes No Amount: _____

Did you use alcohol and/or drugs: Yes No Type and amount: _____

While pregnant, did you have any medical or emotional difficulties: (e.g. Hypertension, surgery, medication, depression etc)

Birth:

Length of labor: _____ Induced: Yes No Caesarian: Yes No

Describe any physical or emotional complications with delivery:

Baby's birth weight: _____ Baby's birth length: _____

Describe any complications for mother or baby after birth:

Length of hospitalization: Mother: _____ Baby: _____

INFANCY/TODDLERHOOD (check all that apply)

- Breast Fed Milk Allergies Vomiting Diarrhea
- Bottle Fed Constipation Colic Rashes

Describe any particular eating or feeding problems: (e.g. overeating, under eating):

Describe your child as an infant: (e.g. happy, nervous, overactive, under active, playful, etc.)

Describe any changes/differences as a toddler:

Describe any past/current problems with wetting or soiling:

Describe any past/current sleeping problems:

Other than parents, describe significant caretakers:

Child's Age	Caretaker (babysitter, relative, etc)	Describe arrangements
_____	_____	_____
_____	_____	_____
_____	_____	_____

DEVELOPMENTAL HISTORY:

Age at which child:

Sat alone: _____	Toilet trained: _____
Took first steps: _____	Dry during day: _____
Spoke words: _____	Dry during night: _____
Spoke sentences: _____	Dressed self: _____
Weaned: _____	Tied shoelaces: _____
Fed self: _____	Rode 2-wheel bike: _____

PAST/CURRENT DIFFICULTIES WITH ANY OF THE FOLLOWING:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Attachment to doll, stuffed animal, blanket, etc | <input type="checkbox"/> thumb sucking | <input type="checkbox"/> fears |
| <input type="checkbox"/> nervous habits (eye blinking, nail biting, etc | <input type="checkbox"/> teeth grinding | <input type="checkbox"/> fascinations |
| <input type="checkbox"/> over activity | <input type="checkbox"/> social contacts | <input type="checkbox"/> head banging |
| <input type="checkbox"/> imaginary friends | <input type="checkbox"/> temper tantrums | <input type="checkbox"/> masturbation |
| <input type="checkbox"/> sexual difficulties | <input type="checkbox"/> short attention span | <input type="checkbox"/> other |
| <input type="checkbox"/> separation difficulties | | |

If yes, describe when and nature of problem:

AGE FOR FOLLOWING DEVELOPMENTS: (to be completed where applicable)

Voice change: _____ Breast development: _____ Body hair: _____ Menstruation: _____

MEDICAL:

Immunization Record:

	DTP	POLIO	
2 months:	_____	_____	
4 months:	_____	_____	15 months _____ MMR(Measles, Mumps, Rubella)
6 months:	_____	_____	24 months _____ HBPV (hib)
1 ½- 2 years:	_____	_____	Hepatitis Series _____
4- 5 years:	_____	_____	

IV. SOCIAL BEHAVIOR:

How well does your child get along with other children his/her own age:

Does child have friends: yes no Duration of best friendship: _____

Your opinion of child's choice of friends:

Family members your child is close to:

Family members your child has difficulties with:

THERAPY IMPLICATIONS:

3) Interests/Hobbies

Art _____

Book/Films _____

Music _____

Physical Fitness _____

Crafts _____

Outdoor Activity _____

Sports _____

Diet/Health _____

Current Memberships (church , clubs, organizations) _____

Do you participate in any cultural activities related to your ethnic background? Yes No

THERAPY IMPLICATIONS:

DESCRIBE THE FOLLOWING:

Recent change in child's feelings/attitudes toward family members:

Physical, emotional, sexual abuse, past or present:

Child's problem behavior (s):

Effect of problem behaviors on other family members:

Child's response to authority figures and reasonable limit setting:

Geographical moves (how many, when, where, and child's response)

EDUCATION:

Present School: _____ School Phone#: _____

Grade: _____ Teacher: _____ School Counselor: _____

DESCRIBE THE FOLLOWING:

Placement in gifted/special education program:

Retention or acceleration in grade placement:

Past/current behavioral adjustment in school:

Past/current academic performance in school:

Your opinion of child's academic performance:

Child's attitude toward school:

Other pertinent information:

4) **Spirituality**

Do you believe in a god or a power greater than yourself? Yes No

What religion were you raised _____

What religion are you currently affiliated _____

At this point in your life, what is most important to you _____

THERAPY IMPLICATIONS:

V. **EMPLOYMENT/VOCATIONAL**

Has child had any after school jobs? yes no

If yes: Where _____ Dates _____

THERAPY IMPLICATIONS:

VI. **LEGAL DATA**

Are you presently on probation or parole: Yes No

If yes reason _____ From _____ To _____

Current Status:

Are you currently involved in any active legal cases (traffic, civil, criminal): Yes No

If yes, please describe and indicate the court hearing/trial date _____

THERAPY IMPLICATIONS:

VII Nutritional Assessment

Please circle the answer or indicated number and total the score from both columns at the bottom.

QUESTION	YES	NO
Do you have an illness/condition that made you change the type/amount of food you eat?	Yes=2	No
Do you eat at least two or more meals per day?	Yes	No=3
Do you eat fruits or vegetables, or milk products every day?	yes	No=2
Do you have 3 or more drinks of beer, liquor, or wine almost every day?	Yes=2	no
Do you have teeth or mouth problems that make it hard for you to eat?	Yes=2	no
Do you always have enough money to buy the food you need?	yes	No=4
Do you eat alone most of the time?	Yes=1	no
Do you take 3 or more prescription or over-the-counter drugs?	Yes=1	No
Have you lost or gained 10 lbs. in the last six months?	Yes=1	No
Are you always physically able to shop, cook, and/or feed yourself?	Yes	No=2

TOTAL SCORE _____

0-2= Low Risk 3-5= Moderate Risk 6-21= High Risk* *Referral

THERAPY IMPLICATIONS:

VII. MEDICAL INFORMATION (past and present)

1. Recent Treatment History

	Date	Reason	Results
Last physical check-up			
Last Doctor's visit			
Last Dental visit			

2. Review of Past/Present Conditions

Please check any of the following medical problems you have, or have had in the past:

- Adrenal problems
- Diabetes
- Thyroid problems
- Seizures/Epilepsy
- Meningitis or Encephalitis
- Head Injury/Loss of Consciousness
- Kidney/Bladder problems
- High Blood Pressure
- Stroke
- Sexually transmitted disease
- Anemia
- Liver problems
- Lung problems
- Heart problems
- Allergies
- Brain Tumor
- Cancer
- Glaucoma
- Asthma

If yes to any of the above, please describe and give dates:

3. Is child in any physical pain? yes no

If yes: where/what kind? _____

If yes please rate pain _____ 0=none 5= mild(tolerable) 10=severe (referral)

4) Current Medical Symptoms/Problems:

Please check all that pertain to you now:

EYES

- Double Vision
- Eye pain
- Problems with vision

EARS

- Hearing Aid
- Buzzing/Ringing in ears
- Infection in ears
- Problems with balancing
- Problems with hearing

NOSE

- Nose bleeds
- Stuffy nose

MOUTH

- Loss of taste
- Problems with teeth
- Dentures

irregularities

RESPIRATORY

- Shortness of breath
- Chronic cough
- Sputum/mucus production
- Positive TB test
- Coughing up blood

SKIN/JOINT/MUSCLE

- Changes in skin
- Changes in nails
- Changes in hair
- Skin rash
- Skin itchy/dry
- Cramps in legs/arms
- Stiff/swollen joints
- Difficulty walking

GASTROINTESTINAL

- Difficulty swallowing
- Heartburn
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Blood in stool
- Black tarry stool
- Abdominal pain

GENITO/URINARY

- Pain/burning with urination
- Frequent urination at night
- Bloody/brown urine
- Difficulty starting urine flow
- Constant need to urinate

NERVOUS SYSTEM

- Headaches
- Numbness
- Fainting spells
- Convulsions/seizures
- Memory problems
- Coordination problems
- Tremor/shakes
- Loss of movement
- Loss of sensation

GENERAL HEALTH

- Overweight
- Underweight
- Chills
- Fever
- Tire easily
- Night/day sweats

CARDIOVASCULAR

- High blood pressure
- Low blood pressure
- Heart skips a beat
- Palpitations
- Fast heart rate
- Chest pains
- Swollen ankles

FEMALES ONLY

- Menstrual
 - Menopause
- Problem pregnancy
- Miscarriage # _____
- Abortion # _____
- Premenstrual problems
- Infertility
- Currently pregnant

If you checked any of the above, please describe: _____

5) Medication and Drug Use

Include prescription, non-prescription, and illegal drugs

Name of Drug	Prescribed	Prescribing Physician	Date 1st used	Date last used	Amount last used	Used in past 48 hr
	yes no					
	yes no					
	yes no					
	yes no					

Any history of drug overdose: Yes No If yes, please describe: _____

Any history of drug allergies: Yes No If yes, please describe: _____

THERAPY IMPLICATIONS: _____

8. **Trauma**

Any history of trauma, abuse, neglect or exploitation? No Yes

If yes: When and type _____

THERAPY IMPLICATIONS:

Do you believe child would benefit from any of the following?

Anger Management Education Series Substance Abuse Education Series Grief Group

STAFF USE ONLY

Client currently being treated by Primary Care Physician for symptoms checked on page 8

yes no n/a

Referred for physical yes no

CLINICIAN SIGNATURE/CREDENTIALS

DATE

PSYCHOLOGIST SIGNATURE

DATE

Physician agrees disagrees with referral

If disagree reason _____

PHYSICIAN SIGNATURE

DATE