CHILD AND ADOLESCENT PERSONAL HISTORY FORM

□ MENTAL HEALTH □ SUBSTANCE ABUSE

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
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)

□ Medical/Organic condition
□ Depression
□ Mania
□ Chemical Abuse/Dependency
□ Delusions/Hallucinations
□ Family Issues
□ Relationship Issues
□ Other (please elaborate)

□ Anxiety
□ Aggressive Behavior
□ Suicidal Ideation's
□ Self-destructive Behavior
□ Anger
□ Life Decision
□ Uncertain

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

1. **Family Constellation**

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

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 uninvolved

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: _____
Took first steps: _____
Spoke words: _____
Spoke sentences: _____
Weaned: _____
Fed self: _____

Toilet trained: _____
Dry during day: _____
Dry during night: _____
Dressed self: _____
Tied shoelaces: _____
Rode 2-wheel bike: _____

PAST/CURRENT DIFFICULTIES WITH ANY OF THE FOLLOWING:

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

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 long 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/trail 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**

Please fill out alcohol/substance use only if your child is 12 years old or older.

X <u>Alcohol/Substance Use</u>

Substance preferred _____

Date of last drink_____/ Date of last drug use _____

Type and amount of drink at last episode □ Beer _____oz □ Wine _____ oz □ Liquor ____ oz

Age drinking/ drug use began_____

Type of alcohol preferred: □ Beer □ Wine □ Liquor

How often do you drink/use drugs? □ Daily □ Weekly □ Monthly □ Other

Have you ever had any legal problems related to your use of alcohol/drugs? □ Yes □ No

Have you ever had any relationship problems related to your use of alcohol/drugs? □ Yes □ No

*****Has drinking or drug use ever become a problem? □ Yes □ No**

*****If YES, please complete next page. (Substance Abuse Addendum)**

If NO go to page 10

THERAPY IMPLICATIONS:_____

SUBSTANCE USE ADDENDUM

I. USAGE HISTORY

Drug type	Method of use	Age first used	Age of regular, daily use	Date last used	Last 48 hours	Last 30 days	Last year
A. DEPRESSANTS							
Alcohol (beer, wine, liquor)							
Anti-Anxiety Agents (Valium, Librium, Tranxene, Xanax, Ativan, Serax, etc.)							
Barbiturates (Phenobarbital, Tuinal, Seconal, etc.)							
Others (Methaqualone, Paraldehyde, Equanil, Miltown, muscle relaxants, etc.)							
B. NARCOTICS (Heroin, Opium, Morphine, Codeine (Tylenol #3/#4, Cough Syrup), Methadone, Dilaudid, Percodan, Darvon, Talwin, etc.)							
C. STIMULANTS							
Amphetamines (Benzedrine, Dexedrine, Ritalin, etc.)							
Cocaine/Crack							
Caffeine							
Nicotine							
D. CANNABIS (Marijuana, Hashish)							
E. INHALANTS (glue, poppers, gasoline, etc.)							
F. HALLUCINOGENS							

THERAPY IMPLICATIONS: