

Personal History Form- Child and Adolescent

Child's Name _____ Todays Date _____

Date of Birth _____ Religion / Spirituality _____

Race / Ethnicity _____ Gender: _____

Name of person completing this form: _____ Relationship to child: _____

Does this child live with you: Yes No Do you have legal custody: Yes No

If No legal custody, please explain: _____

If Yes legal custody, please list the names of any other adult who also has legal custody (e.g., another parent, whether in the home or outside of the home):

Home Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Ok to leave message? Yes No

Mobile Phone _____ Ok to leave message? Yes No

Information for Clients

Your child's intake consists of a series of questionnaires and an interview lasting about 90 minutes. Rather than focus on a list of questions during the initial interview we prefer to focus on your child's current concerns and goals and how we can help your child. Completing this form will help with that process.

Intake Questions

Child's current living situation: Apartment/Rent Own Home

If divorced parents, is child going between homes or mainly at one? _____

Please list the names, ages, and relationships of the people your child lives with.

Name _____ Age _____ Relationship _____

Please tell us about any concerns you have regarding your child's current housing situation.

Is your child currently employed? Yes No Briefly describe your child's current and past employment history.

Dates of Employment	Place of Employment	Job Title	Job Duties	Any Job Problems?

Please tell us about any concerns you have regarding your child's current employment situation.

Child's primary physician name and phone number:

Date of child's last physical exam: _____

Please list your child's current medical diagnosis: _____

Please list any surgeries and dates: _____

List **all** medications, drugs, or other substances your child is currently taking or has taken in the last year—prescribed, over-the-counter vitamins, herbs, and others. If you have a list, you can provide a copy of the list.

Medication / Drug	Dose	How often?	Taken since (start date)	Reason to take it?	Is it effective?

Does your child have any medication or food allergies? Yes No Unsure

If yes, please specify: _____

Does your child have any history of concussions / loss of consciousness? Yes No Unsure

If yes, when? _____

Is this child adopted? Yes No Is this child in foster care? Yes No

If this child is adopted or in foster care, from what age? _____

How old was the mother (or birth mother, in case of adoption or foster care) when she became pregnant with this child? _____

How long was the pregnancy: Full Term Other (specify): _____

Were there any problems during the mother's pregnancy with this child? Yes No Unsure

If yes, please specify: _____

Is your child attending school? Yes No

Name of school _____

Please briefly list information about your child's educational history.

School Name	Grade(s) Attended	Year(s) Attended	Graduated (Yes/No/Not Applicable)	Graduation Year	Any accommodations?

Best subject(s): _____ Worst subject(s): _____ Failed or repeated any grades? Yes No

SAT scores? _____ Any other known standardized test scores? _____

Has your child received special education services or other special help in school (IEP or 504 plan)? Yes No

Please tell us about any concerns you have regarding school: _____

Does your child drink alcoholic beverages? Yes No

If yes, how much and how often? _____

Does your child consume nicotine or tobacco? Yes No

If so, please specify # of cigarettes/e-cigarettes/tobacco per day: _____

Does your child have any previous psychiatric diagnoses? Yes No Unsure

If yes, please specify: _____

Has your child ever been hospitalized for any emotional or psychiatric reason? Yes No Unsure

If yes, how many times has your child been hospitalized? _____

Date(s) of Treatment	Name of Hospital	Reason for Hospitalization	Was It Helpful?

Has your child ever received psychiatric or psychological treatment before (e.g. counseling)? Yes No Unsure

If yes, please complete:

Date(s) of Treatment	Name of Clinician	Reason for Treatment	Was It Helpful?

Is your child taking any medication for psychiatric reasons? Yes No Unsure

If yes, please complete:

Medication	Dose	Frequency	Name of Prescriber

Has your child ever made a suicide attempt? Yes No Unsure

If yes, how many times? _____

Approximate Date	What Did Your Child Do To Hurt Him/Herself?	Was Your Child Hospitalized?

Has your child ever experienced emotional or verbal abuse? Yes No Unsure

Has your child ever experienced sexual abuse? Yes No Unsure

Has your child ever experienced non-sexual abuse? Yes No Unsure

Have you ever been concerned about your child's sexual behavior in terms of unusual practices, addiction, high-risk, identity confusion, or other matters?

Yes No Unsure

Does your child have any criminal history, including arrests and penalties, or is your child currently involved in any legal actions?

Yes No Unsure

Has anyone in your family ever made a suicide attempt?

Yes No Unsure

If so, how is this person related to your child? _____

Has anyone in your family died from suicide?

Yes No Unsure

If so, how is this person related to your child? _____

Does anyone in your family have a history of mental illness, alcohol abuse, drug abuse, or other addictions?

Yes No Unsure

If so, how are these people related to your child, and what is a summary of their problems?

Do you have any concerns regarding your child in any of the following areas? Check all that apply.

Appetite Sleep Concentration / Memory Energy Motivation

Physiological symptoms (heart racing, shortness of breath, hands trembling, nausea, etc.)

Ability to enjoy pleasurable activities Helpless / Hopeless / Worthless Hearing / Seeing things that others do not see

Paranoia Other

If other, please specify: _____

Scheduling Preferences

Services Requested (check all that apply): Individual Family Group

Please provide your child's availability for appointments below:

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Other Information

Is there any other information that you would like to share about your child?

