Comprehensive
Counseling Services

Patient Name:_________________________________

Child / Adolescent History Form

Please provide the following to help us understand your child's living situation:

Child's Last Name ____________________________________ First _____________________________MI_______

Date of Birth _______________ Age ______ Gender _______ Language __________________

Lives with ____ Relationship_______________________________

Primary Address ____ City ____________________ Zip________________

Home Phone ___________________ Cell Phone ____________________ Work Phone _________________________

Parent Name____ Age__________

Address ❐ same as above, or _______________________________City __________________ Zip_________________

Home Phone ___________________ Cell Phone ____________________ Work Phone_________________________

Marital Status (circle) single married separated divorced widowed cohabitating other

Parent has (circle all) primary custody joint custody primary placement shared placement other

Other members of household (list) ____

Parent Name ____ Age__________

Address ❐ same as above, or _______________________________City __________________ Zip_________________

Home Phone ___________________ Cell Phone ____________________ Work Phone _________________________

Marital Status (circle) single married separated divorced widowed cohabitating other

Parent has (circle all) primary custody joint custody primary placement shared placement other

Other members of household (list) ____

Siblings Names	Sex	Age	Type (Bio, Step, Half, etc)	Living Situation

Patient Name:________________________________

Instructions: Please provide the following information to assist us in best helping your child and family.

Child's Name ________________________________ **Today's Date** ____________________

Name of Parent/Guardian completing form: ____

What problem is your child having that concerns you?

____

____

____

____

When did the problem start?

____

Has the child ever received mental health treatment? If so, where, when and by whom? ____________________

____

Has the child ever taken medication for emotional or behavioral problems? If so, what, when and by whom? ________

____

What do you see as your child's strengths? ____

____

In the past month, what has been your child's biggest success or accomplishment? ____________________

____

Who does your child look to for help and support? ____________________________________

____

What are your family's strengths? ____

____

Who do you as a parent rely on for support and assistance? ______________________________

____

Is your child receiving any other special help or therapies? (List)

____

____

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Medical History

Please answer the following questions regarding your pregnancy and delivery with this child:

Pregnancy ❒ Mother was healthy

❒ Mother had health problems: ____

❒ Mother smoked ❒ Used alcohol ❒ Used drugs

❒ Violence toward mother during pregnancy

Delivery ❒ Full-term ❒ Premature at ____ months ❒ Adopted at __________ of age

❒ List any medical complications ____

❒ List any congenital problems ____

❒ Extended hospital stay for ❒ Infant and/or ❒ Mother

Has your child had a history of medical problems? (Describe)

____

____

____

Have there been significant hospitalizations, operations, procedures or injuries? (Describe)

____

____

Are there current medical problems or concerns? (Describe)

____

____

____

____

Is the child currently taking medication? (List medication, dosage, reason for medication and prescribing physician)

____

____

____

____

Name of Child's Primary Care Physician/Pediatrician ______________________________________

Address:______________________________________ Phone: ____________________

Has your child seen the Primary Care Physician/Pediatrician within the past year? ❒ Yes ❒ No

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Below is a list of developmental concerns or problems. Check (X) all that apply to your child.

	Description	At what age(s)?	Current Status (Describe)
	Slow to crawl		
	Slow to walk		
	Slow to talk		
	Not like being touched or held		
	Difficulty with toilet training/bedwetting/soiling		
	Problems with sleep		
	Problems with eating		
	Easily upset/hard to calm down		
	Not like being around people		
	Too active for child's age		
	Low energy		
	Physical disability		
	Learning problems		
	Other:		

Check (x) and complete if your child is currently enrolled in:

❒ **School** Name ______________________________ Address ______________________

Teacher ______________________ Grade _____ Phone Number __________________

Does your child have an IEP? ❒ No ❒ Yes, for _______________________________

❒ **Childcare** Name ___________________________ Address ______________________

Contact person ___________________________ Phone Number __________________

❒ **Other program** Name _______________________ Address ______________________

Contact person ___________________________ Phone Number __________________

Below is a list of experiences that some children have had to deal with. Check (x) all that apply to your child.

	Teasing or bullying by another		Physical abuse
	Conflict in family		Sexual abuse
	Separation from parent(s)		Emotional or verbal abuse
	Frequent moves in location		Witnessing violence at home
	Divorce		Witnessing violence in the community
	Medical emergency or difficult procedure		A hurricane, flood, tornado or other bad storm
	Death or loss of someone close		Car crash or other serious accident
	Medical problem of parent		Family member victim of crime
	Emotional problem of parent		Other event that extremely upset or bothered child
	Drug/alcohol problem of parent		(describe)
	Foster care		

What would like to see change for your child as a result of treatment? For yourself as a parent?

____

____

____

Thank you for providing this information.