

Comprehensive

Counseling Services

Patient Name: _____

CHILD/ADOLESCENT HISTORY FORM

Date of Birth: _____

INSTRUCTIONS: Your doctor/therapist would like you to answer the following questions. This will help him or her to better understand your child's situation.

Name of Parent/Legal Guardian completing form: _____

Relationship to Patient: Biological Child Adopted Child Step Child Foster Child

PSYCHOLOGICAL HISTORY

A. What problem(s) caused you to come for treatment at Comprehensive Counseling? _____

When did the problem begin? _____

Who made the decision to come to treatment? _____

B. Have there been any recent illnesses or deaths among your family or close friends? Yes No

C. Have there been any recent crises or major changes for your family? Yes No

D. Any history of emotional, physical or sexual abuse in the family? Yes No

E. Has your child ever intentionally hurt himself/herself or made a suicide attempt? Yes No

F. Has your child ever run away? Yes No

G. Have your child or any family member ever taken medication for anxiety,

H. depression, sleep or other emotional conditions? Yes No

I. Have you or your child ever been in counseling before? Yes No

J. If so, for what issues? _____

K. When and where did you receive counseling? _____

L. Any hospitalizations in the family for emotional problems? Yes No

M. Please name any people or organizations that you believe provide help and support for you. _____

MEDICAL HISTORY

A. List any current medical problems for your child: _____

B. Are any medications taken for these conditions? Yes No

List current medications & dose: _____

C. List any complications during pregnancy, birth or early developmental milestones for your child: _____

D. List other major medical conditions your child had in the past (include any surgeries): _____

E. Name of your child's primary care physician: _____ Phone: _____

F. Address of child's primary care physician: _____

G. Can we contact your child's physician to let them know you are being treated? Yes No

H. When was your child's last medical exam? _____

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I. Other important medical history about your family including any inherited diseases or disabilities: _____

J. Check any of these problems or symptoms your child has experienced in the past year:

- | | | |
|--|---|---|
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Learning disability | <input type="checkbox"/> Changes/problems in eating |
| <input type="checkbox"/> Refuses to obey | <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Changes/problems in sleeping |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Bedwetting or soiling |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Speech problems | <input type="checkbox"/> School problems |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Low energy / fatigue | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Other _____ | |

DRUG AND ALCOHOL USE

A. Please describe the drug and alcohol use of your family. Use the number which best describes how often each person uses each drug. For siblings, please write in the name at the top of each column.

0 = never; 1 = less than once a month; 2 = 1-4 days a month; 3 = almost daily; 4 = daily; 5 = used in past, not using now

SUBSTANCE	CHILD	MOTHER	FATHER	SIBLING	SIBLING	SIBLING
Caffeine	_____	_____	_____	_____	_____	_____
Nicotine	_____	_____	_____	_____	_____	_____
Beer/wine/liquor	_____	_____	_____	_____	_____	_____
LSD	_____	_____	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____	_____	_____
Sedatives	_____	_____	_____	_____	_____	_____
Amphetamines	_____	_____	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____	_____	_____
Other (specify)	_____	_____	_____	_____	_____	_____

- B. Are you concerned about your child's drug or alcohol use? Yes No
- C. Are you concerned about the alcohol or drug use of someone else in your family? Yes No
- D. Has anyone in your family been in treatment for drug or alcohol abuse? Yes No
- List who and for what treatment: _____

FINANCIAL / LEGAL HISTORY

- A. Has your child ever had problems with the police? Yes No
- B. Have your child ever been involved with Protective Services? Yes No

SCHOOL HISTORY

- A. Where is your child currently enrolled in school? _____
 Address: _____ Phone: _____
- B. Who is the primary contact person at your child's school: _____
- C. What is your child's highest grade completed? _____
- D. Does your child have a problem with school attendance? Yes No
- E. Does your child have a problem with school behavior? Yes No
- F. Does your child have a problem with his or her grades? Yes No

THANK YOU FOR COMPLETING THIS INFORMATION.