Christian Counseling Centers of Indiana, LLC

CHILD/ADOLESCENT PERSONAL HISTORY
(AGES 17 AND UNDER)

TO BE COMPLETED BY PARENT OR GUARDIAN. THE INFORMATION YOU PROVIDE TO US WILL BE VERY HELPFUL IN TREATING YOUR CHILD. PLEASE FILL OUT COMPLETELY. IF YOU HAVE ANY DIFFICULTY, COMPLETE AS MUCH AS POSSIBLE. YOUR CHILD'S THERAPIST WILL REVIEW THE FORM WITH YOU. THANK YOU!

Today's Date: _____ Your Name: _____

Child's Name: _____ Age: _____

How are you related to the child? _____

		AGE
Child's Parents:	_____	_____
Step-parents:	_____	_____
Child's Brothers and Sisters:	_____	_____
B=Brother	_____	_____
S=Sister		
SB=Step-brother	_____	_____
SS=Step-sister		
HB=Half-brother	_____	_____
HS=Half-sister		
	_____	_____
(If any of above are deceased, put a "D" and year in the Age column.) Example: D1987	_____	_____
	_____	_____

Child was raised by: _____

Who lives in child's main household? _____

_____

Whose idea was it to bring child to clinic? _____

What problems is your child having?_____

_____

_____

_____

When has he/she been having these problems? _____

Why do you think your child is having problems?_____

_____

Describe how child's problems affect you, other family members, others:_____

_____

_____

_____

What would you or referring person like to see done for your child? _____

_____

_____

When and where has your child been evaluated or counseled before? _____

_____

Reason: _____

Has child ever threatened/attempted to HARM self or others?_____

Explain: _____

Have child's parents or any close relatives ever been in counseling at a clinic or been hospitalized for depression, hearing voices, alcohol or drug problems, suicide attempts, etc? Please explain who, where, when:

Who? _____ When? _____ Where? _____ Why? _____

Who? _____ When? _____ Where? _____ Why? _____

Who? _____ When? _____ Where? _____ Why? _____

How is child's PHYSICAL HEALTH? _____

Has child had serious illnesses, injuries, surgeries, hospitalizations? _____

Explain: _____

Child's Physician: _____ Phone: _____

Office Address: _____ Phone: _____

Date child last saw physician: _____ Reason:_____

Results of Doctor visit:_____

Immunizations up-to-date: _____

Medications child is on: _____

Child's Height: _____ Weight: _____ Appetite: _____

Describe any recent weight gain/loss:_____

Does child over-eat? _____ Refuse food? _____ Purge? _____

Any food or medication allergies? _____

Child's usual energy/activity level: _____

DEVELOPMENTAL HISTORY:

Was your pregnancy desired? _____ Length of term: _____

Problems during pregnancy (include alcohol/drug usage by mother):_____

_____

Complications during delivery: _____

Explain if mother/child separated after birth: _____

_____

Other parent/child separations:_____

Describe child as an infant/toddler (cheerful, fussy, cuddly, withdrawn): _____

_____

Age child first sat up: _____ took steps: _____ spoke words: _____
Age first spoke in sentences: _____ weaned: _____ fed him/herself: _____
Age toilet-trained during day: _____ night: _____ problem now? _____
Age dressed self: _____ tied shoe-laces: _____ rode 2-wheel bike: _____
Age his voice changed (adolescent males): _____ developed body hair: _____
Age 1st menstruation (adolescent female): _____ breast development: _____

SCHOOL: _____ Grade: _____

Address: _____ Phone: _____

Teacher: _____ Counselor: _____

In special classes?_____ Since what grade? _____

Learning disabilities? _____

Has child repeated any grades? _____ Which grades?_____

Describe attendance:_____

Describe effort/attitude toward school: _____

Describe academic performance: _____

Describe behavior in school:_____

When did school performance/behavior change?_____

Why do you think it changed? _____

Education of each parent/guardian: _____

_____

Client Name: _____

Employment/training/work hours of each parent/guardian:

You: _____

Spouse/partner: _____

ETHNIC/CULTURAL background of child: _____

RELIGIOUS/SPIRITUAL background: _____

LEGAL problems of child (past and present): _____

_____

PARENT/CHILD RELATIONSHIP:

How do you and spouse/partner show affection to child? _____

_____

If one of child's biological parents is out of the home, describe his/her relationship with child: _____

_____

RESPONSIBILITIES/RULES:

_____

_____

How does child handle these? _____

Has child threatened/attempted to run away or stayed out all night? _____

Explain: _____

What do you and your spouse/partner DO when your child misbehaves?

You: _____

Spouse/partner: _____

How do you and spouse/partner feel about using PHYSICAL DISCIPLINE?

You: _____

Spouse/partner: _____

Has family ever been involved with Protective Services? _____

When? _____ Reason: _____

Describe any BEHAVIOR of yourself, partner, or other adults in the home (drinking, drugs, verbal or physical conflict, suicide attempts, etc.) that may have affected your child: _____

_____

_____

_____

_____

Describe any EVENTS--family illness, death, separation, divorce, move to a different neighborhood or school, change in family finances, etc.-- that may have affected your child: _____

_____

_____

PLEASE REVIEW THE FOLLOWING LIST AND CIRCLE THE NUMBERS THAT YOU FEEL FIT YOUR CHILD. THEN WRITE THOSE NUMBERS BELOW AND BRIEFLY EXPLAIN:

1. Speech difficulties
2. Nervous habits/behavior
3. Frequent headaches
4. Frequent stomach-aches
5. Difficulty sleeping
6. Lacks guilt/remorse
7. Difficulty making friends
8. Difficulty keeping friends
9. Little interest in friends
10. Little interest in activities
11. Disrespectful/argumentative
12. Doesn't complete schoolwork
13. Acts before thinking
14. Short attention-span
15. Unable to sit still
16. Overactive
17. Underactive
18. Sucks thumb
19. Bangs head
20. Grinds teeth
21. Nightmares
22. Seems angry
23. Hurts animals
24. Sets fires
25. Steals
26. Lies a lot
27. Too serious
28. Fights a lot
29. Clowns a lot
30. Acts spoiled
31. Temper tantrums
32. In own world
33. Afraid/fearful
34. Accident-prone
35. Seems insecure
36. Sad/depressed
37. Worries a lot
38. Cries frequently
39. Mentally slow
40. Interested in sex
41. Looks "high" often
42. Separation problems
43. Imaginary friends
44. Ignores rules
45. Defies authority

#_____ Explain: _____

#_____ Explain: _____

#_____ Explain: _____

#_____ Explain: _____

#_____ Explain: _____

#_____ Explain: _____

#_____ Explain: _____

INTERESTS/ACTIVITIES (Please circle or check):

Watch television	Play sports	Sew	Skate	Baby-sitting
Be with friends	Ride Bicycle	Draw	Write	Imaginary play
Play video games	Roller blade	Read	Scouts	Action figures
Listen to music	Build things	Sing	School	Power Rangers
Talk on phone	Collect things	Dance	Crafts	Dolls

Other: _____

Activities/Interests child no longer enjoys: _____

If child DRINKS or uses DRUGS, please check _____ and complete next page.

Client Name: _____

TYPE OF DRUG	AGE OF 1ST USE	WHAT AGE WAS CHILD USING IT REGULARLY	AVERAGE NUMBER OF DAYS USED EACH WEEK	ABOUT HOW MUCH WOULD CHILD USE EACH DAY	# DAYS USED IN PAST 30 DAYS	LAST DATE CHILD USED
Coffee, Cola						

Caffeine pills						
Cigarettes						
Beer Wine Liquor						
Marijuana						
Crack cocaine 51's Cocaine powder						
Heroin: Snort Snoot						
Methadone						
Pain Medication Type:						
Tylenol #3 or 4						
Muscle Relaxers Soma, Flexeril Other: _____						
Valium, Librium Other: _____						
Glue Poppers Aerosols						
PCP LSD Mescaline						
Meth-amphetamine						
Phenobarbital Sleeping pills						
Steroids						
Other:						

Therapist/Credentials: _____ Date: _____