INWOOD FAMILY GUIDANCE
& PSYCHOLOGICAL SERVICES PLLC

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Personal History Form - Child

Client's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____ Grade in school: _____

Ethnicity: _____ Religion: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ Ext: _____

Cellular Phone: _____ Pager: _____

Reason For Referral

(If you need any more space for any of the following questions please use the back of the sheet)

Why is the child coming to therapy? _____

_____

How long has this problem persisted? _____

Under what conditions do the problems usually get worse? _____

_____

Under what conditions are the problems usually improved? _____

_____

Primary reason(s) for seeking services:

__ Anger management ____ Anxiety ____ Coping ____ Depression

__ Eating disorder ____ Fear/phobias ____ Family Conflict ____ Sexual concerns

__ Sleeping problems ____ Addictive behaviors ____ Alcohol/drugs ____ Hyperactivity

__ Other mental health concerns (specify): _____

_____

Family History

Parents

With whom does the child live at this time? _____

Please describe the child's current family constellation?

_____

_____

_____

If primary caregivers are separated or divorced:

1. How old was the child at the time if the divorce/separation? _____

2. Who has legal custody? _____

Were the child's primary caregivers ever married? ___ Yes ___ No

Is there any significant information about the caregivers' relationship or treatment toward the child which might be beneficial in counseling? ___ Yes ___ No

If Yes, describe: _____

Client's Primary Caregiver 1 (PCG1)

Name: _____ Age: _____ Occupation: _____ ___ FT ___ PT

Where employed: _____ Work phone: _____

PCG1 education: _____

I was child number _____ in a family of _____ children.

Is there anything notable, unusual or stressful about the child's relationship with you?

___ Yes ___ No If Yes, please explain: _____

_____

For what reasons is the child disciplined by you? _____

How is the child disciplined by you? _____

Briefly describe your style of parenting used in the household: _____

_____

_____

Client's Primary Caregiver 2 (PCG2)

Name: _____ Age: _____ Occupation: _____ ___ FT ___ PT

Where employed: _____ Work phone: _____

PCG2 education: _____

I was child number _____ in a family of _____ children.

Is there anything notable, unusual or stressful about the client's relationship with you?

___ Yes ___ No If Yes, please explain: _____

_____

For what reasons is the child disciplined by you? _____

How is the child disciplined by you? _____

Briefly describe your style of parenting used in the household: _____

_____

_____

Client's Siblings and Others Who live in the household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the child
_____	____	___ F ___ M	___ home ___ away	___ poor ___ average ___ good
_____	____	___ F ___ M	___ home ___ away	___ poor ___ average ___ good
_____	____	___ F ___ M	___ home ___ away	___ poor ___ average ___ good
_____	____	___ F ___ M	___ home ___ away	___ poor ___ average ___ good

Others living in the household			Relationship (e.g., cousin, foster child)	Quality of relationship with the child
_____	___	___ F ___ M	_____	___ poor ___ average ___ good
_____	___	___ F ___ M	_____	___ poor ___ average ___ good
_____	___	___ F ___ M	_____	___ poor ___ average ___ good
_____	___	___ F ___ M	_____	___ poor ___ average ___ good

Comments: _____

_____

_____

Family Health History

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

___ Allergies	____ Deafness	____ Muscular Dystrophy
___ Anemia	____ Diabetes	____ Nervousness/Anxiety
___ Asthma	____ Glandular problems	____ Perceptual motor disorder
___ Bleeding tendency	____ Heart diseases	____ Mental Retardation
___ Blindness	____ High blood pressure	____ Seizures
___ Cancer	____ Kidney disease	____ Spinal Bifida
___ Cerebral Palsy	____ Depression	____ Suicide
___ Cleft lips	____ Migraines	___ Alcohol/Drug Abuse
___ Cleft palate	____ Multiple sclerosis	___ Psychosis/Schizophrenia
__ Attention Deficit	___ Learning Disabilities	___ Speech/Language Problems
__Hyperactivity Disorder	___ Autism	

___ Other (specify):_____

Comments re: Family Health: _____

_____

_____

_____

_____

Childhood/Adolescent History

Pregnancy/Birth

Has the child's birth mother had any occurrences of miscarriages or stillborns? _____ Yes ____ No

If Yes, describe: _____

Was the pregnancy with child planned? __ Yes ____ No Length of pregnancy: _____

Birth mother's age at child's birth: _____ Other guardian's age (s) at child's birth: _____

Child number ____ of __ total children.

How many pounds did the mother gain during the pregnancy? _____

While pregnant did the mother smoke? ____ Yes ____ No If Yes, what amount: _____

While pregnant did the mother use drugs of alcohol? __ Yes ___No, If Yes, type/amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication) ____ Yes ____ No

If Yes, describe: _____

Length of labor: _____ Induced: ___ Yes ___ No Caesarean? ___ Yes ___ No

Baby's birth weight: _____ Baby's birth length: _____

Describe any physical or emotional complications with the delivery: _____

_____

Describe any complications for the mother or the baby after the birth: _____

_____

Length of hospitalization: Mother: _____ Baby: _____

Infancy/Toddlerhood Check all which apply:

__ Breast fed	____ Milk allergies	___ Vomiting	____ Diarrhea
__ Bottle fed	____ Rashes	___ Colic	____ Constipation
__ Not cuddly	____ Cried often	___ Rarely cried	____ Overactive
__ Resisted solid food	____ Trouble sleeping	___ Irritable when awakened	____ Lethargic

Developmental History Please note the age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____

Took 1st steps: _____ Tied shoe laces: _____

Spoke words: _____ Rode two-wheeled bike: _____

Spoke sentences: _____ Toilet trained: _____

Weaned: _____ Dry during day: _____

Fed self: _____ Dry during night: _____

Compared with others in the family, child's development was: __ slow ____ average ____ fast

Description of Developmental Problems:

_____

_____

_____

_____

_____

Age for following developmental indicators (fill in where applicable)

Began puberty: _____ Menstruation: _____

Voice change: _____ Breast development: _____

Issues that affected child's development:

Separation from significant others? ___ Yes ___ No If Yes, from who? _____

Has the child/adolescent experienced death? (friends, family, pets, other) _____ Yes _____ No

If Yes, indicate at what age these losses occurred and describe the child's/adolescent's reaction: __

_____

_____

Have there been any other significant changes or events in your child's life? (family moving, fire, robbery, birth of a sibling, etc.) _____Yes _____No

If Yes, describe: _____

_____

History or recent occurrence(s) of child maltreatment _____ Yes _____ No

If Yes, which type(s) of maltreatment? _____ Verbal Abuse _____ Physical Abuse

_____Sexual Abuse _____Neglect

Please describe history of separation/losses and/or maltreatment : _____

_____

_____

_____

List the child's three greatest strengths:

1) _____
2) _____
3) _____

List the child's three greatest weaknesses or needed areas of improvement:

1) _____
2) _____
3) _____

List the child's main difficulties in school:

1) _____
2) _____
3) _____

List the child's main difficulties at home:

1) _____
2) _____
3) _____

Education

Current school: _____ School phone number: _____

Type of school: ____ Public ____ Private ____ Home schooled ____ Other (specify): _____

Grade: _____ Teacher: _____ School Counselor: _____

In special education? ____ Yes ____ No If Yes, describe: _____

In gifted program? ____ Yes ____ No If Yes, describe: _____

Has child ever been held back in school? ____ Yes ____ No If Yes, describe: _____

_____

Has your child ever been suspended or expelled from school? ____ Yes ____No If Yes, describe: _____

_____

Which subjects does the child enjoy in school? _____

Which subjects does the child dislike in school? _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? ____ Yes ____ No

If Yes, describe: _____

Has the child been evaluated for learning issues? ____ Yes ____ No

If Yes, describe: _____

Check the descriptions which best describe your child and his/her:

Feelings about School Work:

___ Anxious ____ Passive ___ Enthusiastic ____ Fearful
___ Eager ____ No expression ___ Bored ____ Rebellious
___ Other (describe): _____

Approach to School Work:

___ Organized ____ Industrious ____ Responsible ____ Interested
___ Self-directed ____ No initiative ____ Refuses ____ Does only what is expected
___ Sloppy ____ Disorganized ____ Cooperative ____ Doesn't complete assignments
___ Other (describe): _____

Performance in School (Caregiver's Opinion):

___ Satisfactory ___ Underachiever ___ Overachiever
___ Other (describe): _____

Peer Relationships:

___ Spontaneous ____ Follower ___ Leader ____ Difficulty making friends
___ Makes friends easily ____ Long-time friends ___ Shares easily
___ Other (describe): _____

Who handles responsibility for your child in the following areas?

School: ___ PCG 1 __PCG 2 __ Shared ___ Other (specify): _____
Health: ___ PCG 1 __PCG 2 __ Shared ___ Other (specify): _____
Problem behavior: ___ PCG 1 __PCG 2 __ Shared ___ Other (specify): _____

If the child is involved in a vocational program or works a job, please fill in the following:

What is the child's attitude toward work? ____ Poor ____ Average ____ Good ____ Excellent
Current employer: _____ Position: _____ Hours per week: _____
How have the child's grades in school been affected since working? ____ Lower ___ Same ___ Higher
How many previous jobs or placements has the child had? _____
Usual length of employment: _____ Usual reason for leaving: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?

Child's Medical/Physical Health

(check all that apply)

___ Abortion	____ Hayfever	____ Pneumonia
___ Asthma	____ Heart trouble	____ Polio
___ Blackouts	____ Hepatitis	____ Pregnancy
___ Bronchitis	____ Hives	____ Rheumatic Fever
___ Cerebral Palsy	____ Influenza	____ Scarlet Fever
___ Chicken Pox	____ Lead poisoning	____ Seizures
___ Congenital problems	____ Measles	____ Severe colds
___ Croup	____ Meningitis	____ Severe head injury
___ Diabetes	____ Miscarriage	____ Sexually transmitted disease
___ Diphtheria	____ Multiple sclerosis	____ Thyroid disorders
___ Dizziness	____ Mumps	____ Vision problems
___ Ear aches	____ Muscular Dystrophy	____ Wearing glasses
___ Ear infections	____ Nose bleeds	____ Whooping cough
___ Eczema	____ Other skin rashes	____ Other
___ Encephalitis	____ Paralysis	_____
___ Fevers	____ Pleurisy	

Name and address of your primary physician:

Physician's name: _____

Address: _____ City: _____ State: _____ Zip: _____

Most recent physical exam: _____ Results: _____

Height _____ Weight _____

List any major illnesses and/or operations: _____

_____

List any health concerns occurring at present: (e.g., high blood pressure, headaches, dizziness):

_____

_____

List any health concerns (e.g., head trauma, seizures) experienced in the past: _____

_____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? ____ Yes __No

If Yes, describe: _____

_____

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

	Yes	No	Dates of treatment	Where	Reaction or overall experience
Counseling/Psychiatric treatment	____	____			
Suicidal thoughts/attempts	____	____			
Drug/alcohol treatment	____	____			
Hospitalizations	____	____			

Behavioral/Emotional

Please check any of the following that are typical for your child:

___ Affectionate
___ Aggressive
___ Alcohol problems
___ Angry Outbursts
___ Anxiety
___ Attachment to dolls
___ Avoids adults
___ Bedwetting
___ Blinking, jerking
___ Bizarre behavior
___ Bullies, threatens
___ Careless, reckless
___ Chest pains
___ Clumsy
___ Confident
___ Cooperative
___ Cyber addiction
___ Defiant/Argumentative
___ Depression
____ Frustrated easily
____ Gambling
____ Generous
____ Hallucinations
____ Head banging
____ Heart problems
____ Hopelessness
____ Hurts animals
____ Imaginary friends
____ Impulsive
____ Irritable
____ Lazy
____ Learning problems
____ Lies frequently
____ Listens to reason
____ Loner
____ Low self-esteem
____ Messy
____ Moody
____ Sad
____ Selfish
____ Separation anxiety
____ Sets fires
____ Sexual addiction
____ Sexual acting out
____ Shares
____ Sick often
____ Short attention span
____ Shy, timid
____ Sleeping problems
____ Slow moving
____ Soiling
____ Speech problems
____ Steals
____ Stomach aches
____ Suicidal threats
____ Suicidal attempts
____ Talks back

___ Destructive	____ Nightmares	____ Teeth grinding
___ Difficulty speaking	____ Obedient	____ Thumb sucking
___ Dizziness	____ Often sick	____ Tics or twitching
___ Drugs use	____ Oppositional	____ Unsafe behaviors
___ Eating disorder	____ Over active	____ Unusual thinking
___ Enthusiastic	____ Over weight	____ Weight loss
___ Excessive masturbation	____ Panic attacks	____ Withdrawn
___ Expects failure	____ Phobias	____ Worries excessively
___ Fatigue	____ Poor appetite	____ Other:
___ Fearful	____ Poor grades	_____
___ Frequent injuries	____ Fighting	_____

Any additional information that you believe would assist us in understanding your child/adolescent?

_____

_____

_____

What family involvement would you like to see in the therapy? _____

_____

For Psychologist's Use

Date Reviewed By Psychologist: _____/_____/_____

Psychologist's signature/credentials: _____