

ADVANCED COUNSELING SERVICES, P.C.

CHILD AND ADOLESCENT HISTORY

Date: _____ Case # _____

Child's Name: _____ Birthdate: ____/____/____

Person completing form: _____ Relationship to child: _____

Who is the custodial parent? _____

Emergency contact: _____
Name Phone

What are the problems your child is having? _____

Has your child ever spoken about or acted upon: Hurting self? _____ Others? _____

Please explain _____

How does your child feel about being here? _____

Previous counseling or testing? (*outpatient or inpatient, where, when, with whom*) _____

What would you like your child to gain from counseling? _____

FAMILY

	Name	Age	Employer/School	Marital Status
Mother				
Father				
Step-Parent/s				
Brothers/Sisters				

Others living in the home: _____

SCHOOL ADJUSTMENT

School district: _____ School: _____

Has your child ever been afraid to go to school? _____

Present Grade: _____ Repeated a grade? _____ Present grades? _____

Has your child ever had difficulties with: Math _____ Reading _____ Language _____ Speech _____

Has your child ever had special education services? Yes _____ No _____

Have you received any complaints from your child's school about behavior or achievement? _____

Please explain: _____

How does your child relate to peers? _____

LEISURE

How does your child spend free time? (*interests or hobbies*) _____

ADJUSTMENT DIFFICULTIES

Please check any of the following that are typical of child's behavior

- | | | |
|---|--|---|
| <input type="checkbox"/> Does not feel liked | <input type="checkbox"/> Does not feel like self | <input type="checkbox"/> Poor hygiene |
| <input type="checkbox"/> Feels lonely | <input type="checkbox"/> Easy to anger | <input type="checkbox"/> Sleep difficulties |
| <input type="checkbox"/> Shy with children | <input type="checkbox"/> Stubborn | <input type="checkbox"/> Sleep walking |
| <input type="checkbox"/> Shy with adults | <input type="checkbox"/> Defiant | <input type="checkbox"/> Bedwetting-present |
| <input type="checkbox"/> Prefers to be alone | Aggressive with: | <input type="checkbox"/> Bedwetting-past |
| <input type="checkbox"/> Worries | Peers _____ | <input type="checkbox"/> Soiling |
| <input type="checkbox"/> Moody | Siblings _____ | <input type="checkbox"/> Unusual thinking |
| <input type="checkbox"/> Sad | Adults _____ | <input type="checkbox"/> Unusual behaviors |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Needs the last word | <input type="checkbox"/> Violent behavior |
| <input type="checkbox"/> Expect failure | <input type="checkbox"/> Stealing from home | <input type="checkbox"/> Destructive to property |
| <input type="checkbox"/> Does not share | <input type="checkbox"/> Stealing from peers | <input type="checkbox"/> Not always truthful |
| <input type="checkbox"/> Lacks motivation | <input type="checkbox"/> Will not admit blame | <input type="checkbox"/> Fails to understand consequences |
| <input type="checkbox"/> Sexual acting out | <input type="checkbox"/> Sets fires | |
| <input type="checkbox"/> Preoccupied with sexual thoughts | <input type="checkbox"/> Poorly organized | |
| <input type="checkbox"/> Tics or twitches | <input type="checkbox"/> Clumsy | |
| <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> Takes unnecessary risk | |
| <input type="checkbox"/> Ritualistic behavior | <input type="checkbox"/> Short attention span | |
| <input type="checkbox"/> Talks impulsively | <input type="checkbox"/> Daydreams | |
| <input type="checkbox"/> Acts impulsively | <input type="checkbox"/> Jealousness | |
| <input type="checkbox"/> Feelings of guilt | <input type="checkbox"/> Overactive | |

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PERSONAL ADJUSTMENT

How does the child relate to: Mother? _____ Father? _____
A Step-Parent? _____ Their Siblings? _____
Authority Figures? _____

HEALTH QUESTIONNAIRE

Present medication prescribed by the physician: _____

Present medications that do not need a prescription: _____
Medication Allergies: _____
Is there a family history for an illness? (*physical or emotional*) _____
Does the child have a history of substance abuse? If yes, what types? _____

PRESENT HEALTH

Physician: _____ Phone: _____
Address: _____
Date of Last Exam: _____ Results: _____
Are your child's immunizations up to date? _____
Has your child had an eye exam? _____ Glasses? _____
Has your child had an hearing exam? _____ Results: _____
Has your daughter begun menstruation? _____ Age at onset _____
What is your child's present health? _____
Past Health Problems: Hospitalizations, Accidents, Abortions or a Handicap? _____

BIRTH AND DEVELOPMENT

Pregnancy: Normal? _____ If complications, please explain: _____

Any prenatal exposure to alcohol, tobacco, or drugs? _____

Length of labor _____ Premature? _____ weeks. Weight _____

Newborn's Health _____

Infancy: Any Problem Areas?

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Colic | <input type="checkbox"/> Underactive | <input type="checkbox"/> Chronic illness |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Infections | <input type="checkbox"/> High fevers |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Slow growth | <input type="checkbox"/> Hospitalization |
| <input type="checkbox"/> Milk or food allergies | <input type="checkbox"/> Fussy | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Sleep patterning | <input type="checkbox"/> Cried often | |
| <input type="checkbox"/> Overactive | <input type="checkbox"/> Constipation | |

EARLY CHILDHOOD: *(indicate age started)*

Talking: Single words at _____ months; sentences at _____ months.

Walking at _____ months.

Began toilet training at _____ months; completed toilet training at _____ months.

Knew colors at _____ years. Knew numbers at _____ years.

Knew letters at _____ years.

RELIGIOUS AND SPIRITUAL BELIEFS

Mother's background _____ Father's background _____

Does the family practice a religion or spirituality? Please describe: _____

Does your child participate? _____

LEGAL

Has your child ever been involved with the police or the courts? Please explain? _____

_____ On

probation? _____

Has your child been part of divorce or custody issue? _____

Is your child adopted? _____ When were they told? _____

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FAMILY INCOME INFORMATION

Does your child work? _____ Hours: _____ Position: _____

Does the family have financial difficulties? _____

Parent or Guardian's Signature: _____
Date

— For Office Use —

Therapist's Signature *Date*

Physician's Recommendations: _____

Based on the information provided above: A physical exam [] IS [] IS NOT necessary for treatment.

Physician's Signature *Date*