envision
COUNSELING

# Child/Adolescent History Form

Child's Name _____ Today's Date _____

Child's Date of Birth _____ Age _____ Gender: M F

School: _____ Grade _____

Person completing form _____ Relationship to the Child _____

*** Please bring copies of all documents relating to parenting arrangements/responsibilities, time-sharing plans, psychological, educational, or other relevant evaluations to the first appointment.**

Parent A _____

Home Phone _____

Work Phone _____

Cell Phone _____

Home Address _____

_____

_____

Age _____

Occupation _____

Highest Degree _____

Religion _____

Marital Status M S D W

Parent B _____

Home Phone _____

Work Phone _____

Cell Phone _____

Home Address _____

_____

_____

Age _____

Occupation _____

Highest Degree _____

Religion _____

Marital Status M S D W

If parents are divorced, which parent has **primary residential custody?** _____

| Child's siblings/stepsiblings: | Age/Grade | Relationship | List physical and mental health concerns |
|---|---|---|---|
| 1. _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ |

4. _____ _____ _____ _____



Who lives in the primary residential home? _____

Who lives in the child's other home? _____

List other person closely involved with the child but not living in the home: _____

_____

What is the *primary* concern or reason for this referral? _____

_____

_____

How long has this problem existed? _____ Years Months Weeks (circle one)

Please describe any major changes or stresses in the family that have occurred (family illness or death, parental separation, recent or frequent moves, financial stressors, etc.) _____

_____

_____

**Birth/Developmental History:**

Was the child adopted? Yes No If yes, how old was the child? _____

Child's weight at birth _____ Was the baby full term? _____

Circle abuse history? Witness to domestic violence Emotional Physical Sexual No abuse

Explain: (e.g. child's relationship to abuser, was abuse reported, what was the family's response, etc.)

_____

_____

_____

_____

_____

_____

**Medical History:**

Physician's name _____ Phone _____ Date of last checkup _____

How would you describe your child's health? Excellent Good Fair Poor

How would you describe your child's nutritional diet? Excellent Good Fair Poor

How would you describe your child's level of physical activity? Excellent Good Fair Poor

Is there any other medical information you think is important regarding your child? _____

_____

Current Medications:

| Name of medications | Dosage (mg) | Prescribing doctor and phone Number | Reason for medication | Date began |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Educational History:**

Please list the schools your child has attended beginning with:

Kindergarten _____

Elementary _____

Middle _____

High School _____

Has your child been retained? No Yes What grades? _____

Does your child have an IEP? No Yes Explain: _____

Does your child receive any special services? Yes No Explain (e.g. resource room speech, behavior plans, etc.)

_____

What things does your child like to do? _____

_____

What things present difficulty for your child? _____

_____

Is there anything else that seems significant to you that was not addressed elsewhere in this form? Yes No

_____

# Symptom Checklist Child/Adolescent

**Please check any symptoms that describe how you feel, think or behave currently or during the past month.**

| Behavior | CHILD | PARENT | Behavior | CHILD | PARENT |
|---|---|---|---|---|---|
| **Chronic sadness** | ( ) | ( ) | **Low frustration tolerance** | ( ) | ( ) |
| **Crying episodes** | ( ) | ( ) | Irritability | ( ) | ( ) |
| **Hopelessness** | ( ) | ( ) | Problems going to Sleep in own bed | ( ) | ( ) |
| **Difficulty concentrating** | ( ) | ( ) | Memory problems | ( ) | ( ) |
| **Loss of appetite** | ( ) | ( ) | Isolating | ( ) | ( ) |
| **Overeating** | ( ) | ( ) | Reduced interest/pleasure in activities | ( ) | ( ) |
| **Nausea/Vomiting/ stomach aches** | ( ) | ( ) | Panic attacks | ( ) | ( ) |
| **Difficulty making decisions** | ( ) | ( ) | Fear of leaving home | ( ) | ( ) |
| **Tired** | ( ) | ( ) | Avoidance of public places | ( ) | ( ) |
| **Agitation** | ( ) | ( ) | Avoidance of school | ( ) | ( ) |
| **Restlessness** | ( ) | ( ) | Pounding heart/palpitations | ( ) | ( ) |
| **Fearfulness** | ( ) | ( ) | Stomach aches | ( ) | ( ) |
| **Nervous mannerisms** | ( ) | ( ) | Feeling detached from others/life | ( ) | ( ) |
| **Fear of loss of control** | ( ) | ( ) | Nightmares | ( ) | ( ) |
| **Fear of dying** | ( ) | ( ) | Easily startled/upset | ( ) | ( ) |
| **Difficulty focusing** | ( ) | ( ) | Seeing things others do not see | ( ) | ( ) |
| **Tendency to act impulsively** | ( ) | ( ) | Fearful someone is Plotting against you | ( ) | ( ) |
| **Not well organized** | ( ) | ( ) | Taking on too many Tasks | ( ) | ( ) |
| **Racing thoughts** | ( ) | ( ) | Frequent forgetfulness | ( ) | ( ) |
| **Risk taking** | ( ) | ( ) | Difficulty waiting turn | ( ) | ( ) |
| **Aggressive/abusive** | ( ) | ( ) | Problems with peers | ( ) | ( ) |
| **Low self esteem** | ( ) | ( ) | Recent death of family/friend | ( ) | ( ) |
| **Statements of self harm** | ( ) | ( ) | Recent health problems | ( ) | ( ) |
| **Statements of harm to Others** | ( ) | ( ) | Compulsive rituals | ( ) | ( ) |
| **Steals** | ( ) | ( ) | Harm to self | ( ) | ( ) |
| **Poor judgement** | ( ) | ( ) | Harm to others/animals | ( ) | ( ) |