Life's Journey Counseling and Community Services
LaToya Martin-Jackson, MA, LPC, NCC Lic.# 66427

Personal History—Children and Adolescents

Client's name: _____ **Date:** _____

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

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

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

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

Email: _____

Emergency Contact: _____ **Phone:** _____

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

Primary reason(s) for seeking services:

___ **Anger management** ___ **Anxiety** ___ **Coping** ___ **Depression**
___ **Eating disorder** ___ **Fear/phobias** ___ **Mental confusion** ___ **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? _____

Are parent's divorced or separated? _____

If Yes, who has legal custody? _____

Were the child's parents ever married? ___ **Yes** ___ **No**

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

If Yes, describe: _____

Client's Mother

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

Where employed: _____ **Work phone:** _____

Mother's education: _____

Is the child currently living with mother? ___ **Yes** ___ **No**

___ **Natural parent** ___ **Step-parent** ___ **Adoptive parent** ___ **Foster home** ___ **Other (specify):** _____

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

___ **Yes** ___ **No** **If Yes, please explain:** _____

_____

How is the child disciplined by the mother? _____

For what reasons is the child disciplined by the mother? _____

Client's Father

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

Where employed: _____ Work phone: _____

Father's education: _____

Is the child currently living with father? ___ Yes ___ No

___ Natural parent ___ Step-parent ___ Adoptive parent ___ Foster home ___ Other (specify): _____

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

___ Yes ___ No If Yes, please explain: _____

_____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
_____	___	___ 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)**	
_____	___	___ 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
___ Anemia
___ Asthma
___ Bleeding tendency
___ Blindness
___ Cancer
___ Cerebral Palsy
___ Cleft lips
___ Cleft palate
___ Deafness
___ Diabetes
___ Glandular problems
___ Heart diseases
___ High blood pressure
___ Kidney disease
___ Mental illness
___ Migraines
___ Multiple sclerosis
___ Muscular Dystrophy
___ Nervousness
___ Perceptual motor disorder
___ Mental Retardation
___ Seizures
___ Spinal Bifida
___ Suicide
___ Other (specify): _____

Comments re: Family Health: _____

_____

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Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurances of miscarriages or stillborns? ___ Yes ___ No

If Yes, describe: _____

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

Mother's age at child's birth: _____ Father's age 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: _____

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 shoelaces: _____

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

Age for following developments (fill in where applicable)

Began puberty: _____ Menstruation: _____

Voice change: _____ Convulsions: _____

Breast development: _____ Injuries or hospitalization: _____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

_____

_____

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: _____

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 tested psychologically? ___ Yes ___ No

If Yes, describe: _____

Check the descriptions which specifically relate to your child.

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 (Parent's Opinion):

___ Satisfactory ___ Underachiever ___ Overachiever

___ Other (describe): _____

Child's 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: ___ Mother ___ Father ___ Shared ___ Other (specify): _____

Health: ___ Mother ___ Father ___ Shared ___ Other (specify): _____

Problem behavior: ___ Mother ___ Father ___ 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?

Medical/Physical Health

___ 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	

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____ / week	_____	___ No ___ Low ___ Med ___ High
Lunch	____ / week	_____	___ No ___ Low ___ Med ___ High
Dinner	____ / week	_____	___ No ___ Low ___ Med ___ High
Snacks	____ / week	_____	___ No ___ Low ___ Med ___ High

Comments: _____

Most recent examinations

Type of examination	Date of most recent visit	Results
Physical examination		
Dental examination		
Vision examination		
Hearing examination		

Current prescribed medications	Dose	Dates	Purpose	Side effects

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

Immunization record (check immunizations the child/adolescent has received):

	DPT	Polio
2 months	☐	☐
4 months	☐	☐
6 months	☐	☐
18 months	☐	☐
4–5 years	☐	☐

15 months ☐ MMR (Measles, Mumps, Rubella)
24 months ☐ HBPV (Hib)
Prior to school ☐ HepB

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	When	Where	Reaction or overall experience
Counseling/Psychiatric treatment	☐	☐			
Suicidal thoughts/attempts	☐	☐			
Drug/alcohol treatment	☐	☐			
Hospitalizations	☐	☐			

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Behavioral/Emotional

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

- ___ Affectionate
- ___ Aggressive
- ___ Alcohol problems
- ___ Angry
- ___ Anxiety
- ___ Attachment to dolls
- ___ Avoids adults
- ___ Bedwetting
- ___ Blinking, jerking
- ___ Bizarre behavior
- ___ Bullies, threatens
- ___ Careless, reckless
- ___ Chest pains
- ___ Clumsy
- ___ Confident
- ___ Cooperative
- ___ Cyber addiction
- ___ Defiant
- ___ Depression
- ___ Destructive
- ___ Difficulty speaking
- ___ Dizziness
- ___ Drugs dependence
- ___ Eating disorder
- ___ Enthusiastic
- ___ Excessive masturbation
- ___ Expects failure
- ___ Fatigue
- ___ Fearful
- ___ Frequent injuries
- ___ 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
- ___ Nightmares
- ___ Obedient
- ___ Often sick
- ___ Oppositional
- ___ Over active
- ___ Overweight
- ___ Panic attacks
- ___ Phobias
- ___ Poor appetite
- ___ Psychiatric problems
- ___ Quarrels
- ___ 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
- ___ Teeth grinding
- ___ Thumb sucking
- ___ Tics or twitching
- ___ Unsafe behaviors
- ___ Unusual thinking
- ___ Weight loss
- ___ Withdrawn
- ___ Worries excessively
- ___ Other: _____

Please describe any of the above (or other) concerns: _____

How are problem behaviors generally handled? _____

What are the family's favorite activities? _____

What does the child/adolescent do with unstructured time? _____

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

At what age? _____ If Yes, describe the child's/adolescent's reaction: _____

_____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

____ Yes ____ No If Yes, describe: _____

_____

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

_____

_____

_____

Any additional information that would assist us in understanding current concerns or problems?

_____

_____

_____

What are your goals for the child's therapy? _____

_____

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

_____

Do you believe the child is suicidal at this time? _____ Yes ____ ____ No

If Yes, explain: _____

_____

For Staff Use

Therapist's comments: _____

_____

_____

_____

_____

Therapist's signature/credentials: _____ Date: _____/____/_____

Supervisor's comments: _____

_____

_____

_____

_____ Physical exam: _____ Required _____ Not required

Supervisor's signature/credentials: _____ Date: _____/____/_____

(Certifies case assignment, level of care and need for exam)