Comprehensive Counseling Services

Patient Name:_____

Child / Adolescent History Form

Please provide the following to help us understand your child's living situation:

Child's Last Name _____ First _____ MI_____

Date of Birth _____ Age _____ Gender _____ Language _____

Lives with _____ Relationship_____

Primary Address _____ City _____ Zip_____

Home Phone _____ Cell Phone _____ Work Phone _____

Parent Name_____ Age_____

Address ❒ same as above, or _____City _____ Zip_____

Home Phone _____ Cell Phone _____ Work Phone_____

Marital Status (circle) single married separated divorced widowed cohabitating other

Parent has (circle all) primary custody joint custody primary placement shared placement other

Other members of household (list) _____

Parent Name _____ Age_____

Address ❒ same as above, or _____City _____ Zip_____

Home Phone _____ Cell Phone _____ Work Phone _____

Marital Status (circle) single married separated divorced widowed cohabitating other

Parent has (circle all) primary custody joint custody primary placement shared placement other

Other members of household (list) _____

Siblings Names	Sex	Age	Type (Bio, Step, Half, etc)	Living Situation

Comprehensive Counseling Services

Patient Name:_____

Instructions: Please provide the following information to assist us in best helping your child and family.

Child's Name _____ **Today's Date** _____

Name of Parent/Guardian completing form: _____

What problem is your child having that concerns you?

_____

_____

_____

_____

When did the problem start?

_____

Has the child ever received mental health treatment? If so, where, when and by whom? _____

_____

Has the child ever taken medication for emotional or behavioral problems? If so, what, when and by whom? _____

_____

What do you see as your child's strengths? _____

_____

In the past month, what has been your child's biggest success or accomplishment? _____

_____

Who does your child look to for help and support? _____

_____

What are your family's strengths? _____

_____

Who do you as a parent rely on for support and assistance? _____

_____

Is your child receiving any other special help or therapies? (List)

_____

_____

Comprehensive Counseling Services

Patient Name:_____

Medical History

Please answer the following questions regarding your pregnancy and delivery with this child:

Pregnancy ❒ Mother was healthy

❒ Mother had health problems: _____

❒ Mother smoked ❒ Used alcohol ❒ Used drugs

❒ Violence toward mother during pregnancy

Delivery ❒ Full-term ❒ Premature at ____ months ❒ Adopted at _____ of age

❒ List any medical complications _____

❒ List any congenital problems _____

❒ Extended hospital stay for ❒ Infant and/or ❒ Mother

Has your child had a history of medical problems? (Describe)

_____

_____

_____

Have there been significant hospitalizations, operations, procedures or injuries? (Describe)

_____

_____

Are there current medical problems or concerns? (Describe)

_____

_____

_____

_____

Is the child currently taking medication? (List medication, dosage, reason for medication and prescribing physician)

_____

_____

_____

_____

Name of Child's Primary Care Physician/Pediatrician _____

Address:_____ Phone: _____

Has your child seen the Primary Care Physician/Pediatrician within the past year? ❒ Yes ❒ No

Comprehensive Counseling Services

Patient Name:_____

Below is a list of developmental concerns or problems. Check (X) all that apply to your child.

	Description	At what age(s)?	Current Status (Describe)
	Slow to crawl		
	Slow to walk		
	Slow to talk		
	Not like being touched or held		
	Difficulty with toilet training/bedwetting/soiling		
	Problems with sleep		
	Problems with eating		
	Easily upset/hard to calm down		
	Not like being around people		
	Too active for child's age		
	Low energy		
	Physical disability		
	Learning problems		
	Other:		

Check (x) and complete if your child is currently enrolled in:

❒ **School** Name _____ Address _____

Teacher _____ Grade _____ Phone Number _____

Does your child have an IEP? ❒ No ❒ Yes, for _____

❒ **Childcare** Name _____ Address _____

Contact person _____ Phone Number _____

❒ **Other program** Name _____ Address _____

Contact person _____ Phone Number _____

Below is a list of experiences that some children have had to deal with. Check (x) all that apply to your child.

	Teasing or bullying by another
	Conflict in family
	Separation from parent(s)
	Frequent moves in location
	Divorce
	Medical emergency or difficult procedure
	Death or loss of someone close
	Medical problem of parent
	Emotional problem of parent
	Drug/alcohol problem of parent
	Foster care

	Physical abuse
	Sexual abuse
	Emotional or verbal abuse
	Witnessing violence at home
	Witnessing violence in the community
	A hurricane, flood, tornado or other bad storm
	Car crash or other serious accident
	Family member victim of crime
	Other event that extremely upset or bothered child
	(describe)

What would like to see change for your child as a result of treatment? For yourself as a parent?

_____

_____

_____

Thank you for providing this information.