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Child and Adolescent History Form

1. Child/Adolescent Biographical Information

First Name: MI: Last Name: Date of Birth:

Address: City: State: Zip Code:

Parent/Guardian Name(s):

For coordination purposes, is there a primary point of contact between parents/guardians?

2. Counseling Concerns

What are the concerns for which you are seeking help for your child?

What are you hoping you and your child get out of counseling?

3. Family History

Parent/Guardian 1: Date of Birth:

Current Address:
☐ Same as child's

Address: City: State: Zip Code:

Phone Number: Email Address:

Preferred contact method:
☐ Phone ☐ Email

Highest level of education completed: Occupation:

Best times or days to call/get a hold of you?

Medical and Psychiatric history:

Parent/Guardian 2: Date of Birth:

Current Address:
☐ Same as child's

Address: City: State: Zip Code:

Phone Number: Email Address:

Preferred contact method:
☐ Phone ☐ Email

Highest level of education completed: Occupation:

Best times or days to call/get a hold of you?

Medical and Psychiatric history:

Current relationship status of parents:
○ Single ○ Married ○ Divorced ○ Separated ○ Remarried

Names of any stepparents:

Who else lives in the home?

Comments or anything we should know about parents' relationship:

4. Developmental and Social History

Is your child adopted?
○ Yes ○ No

Any complications during pregnancy or birth?
○ Yes ○ No

If yes, please describe:

Did your child meet developmental milestones on time?
○ Yes ○ No

Any developmental milestones not met on time:

Child's reaction to frustration?

Is there anything you would like to address with your counselor regarding parenting or discipline?

How would you describe child's relationship with each parent/guardian?

Does the child have any chores or responsibilities at home?

Describe any concerns regarding child's completion of chores or responsibilities at home:

Describe any spiritual or religious affiliation or preferences:

Any additional information you would like us to know about home or your family:

5. Medical History

Current or past medical issues:

Name of Primary Care Doctor:

Date of your last check up with primary care doctor:

Current medications, including dosages, prescriber of the medication, and any over-the-counter medicines:

Any injuries or accidents, particularly blows to the head (car accidents, bike falls, etc)?

Has your child ever been hospitalized for medical treatment or surgery?
○ Yes ○ No

If yes, at what age and for what reason(s)?

Has your child used or experimented with alcohol, drugs, or nicotine to your knowledge?
○ Yes ○ No

If yes, please provide any additional information you may have about what substances and any concerns you may have regarding their use of alcohol, drugs, or nicotine:

Any difficulties with getting to or staying asleep?
○ Yes ○ No

Estimated hours of sleep your child gets per night:

Does your child have frequent physical complaints or accidents?
○ Yes ○ No

If yes, please describe:

Estimated hours spent on screens per day:

Does your child participate in any social media?
○ Yes ○ No

If yes, which apps?

If applicable, date of last menstrual cycle:

6. Psychiatric History

Has your child participated in therapy before?
○ Yes ○ No

If yes, when, what was the reason, and with whom?

Has your child been hospitalized for psychiatric reasons?
○ Yes ○ No

If yes, when, what was the reason, and where?

Has your child ever expressed suicidal thoughts or feelings?
○ Yes ○ No

If yes, please describe:

Has your child ever expressed homicidal thoughts or feelings?
○ Yes ○ No

If yes, please descibe:

Has your child ever engaged in self-harm?

○ Yes ○ No

If yes, please describe:

Does your child have access to guns?

○ Yes ○ No

7. Educational and Occupational Information

How do you feel about your child's experiences at school?

What do you think is your child's attitude towards school?

Any unpleasant school experiences for your child?

Does your child resist going to school?

○ Yes ○ No

Educational Strengths:

Educational Difficulties:

Does your child have an IEP or 504?

○ Yes ○ No

If yes, please describe goals and accommodations:

Has your child received any testing?

○ Yes ○ No

Is your child currently at risk of retention or exclusion from school?

○ Yes ○ No

8. Trauma History

Does your child have a history of being abused emotionally, sexually, physically, or by neglect?

○ Yes ○ No

If yes, please provide any details you feel comfortable sharing at this time. Please note your counselor may follow up with additional questions.

9. Legal History

Does your child or your family have any past or pending legal issues?

10. Strengths and Interests

What are your child's strengths, abilities, and current special interests?

Who are your child's support systems (family, friends, mentors, coaches, etc)?

11. Additional Comments or issues not addressed in the preceding sections