

HERON RIDGE ASSOCS., PLC
CHILD/ADOLESCENT PERSONAL HISTORY FORM
 Please fill out this form as completely as possible. If question does not apply, mark 'N/A'

Child's Name: _____ Case Number: _____

Birthdate: ___/___/___ Person Completing Form: _____ Relationship to Child: _____

Address: _____

City _____ State _____ Zip Code _____

Phone: Home: _____ Cell/Work: _____

What are the problems that your child is having? _____

How does your child feel about being here? _____

Previous Counseling? (outpatient or inpatient, where, when) _____

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

Describe any problems which occurred in your child's family relating to:

Alcohol / drug use: _____

Sexual / physical / emotional abuse: _____

Family	Name	Age	Employer/School	Marital Status
Mother				
Father				
Step Parent/s				
Siblings				

Others living in the home: _____

Please check any of the following that describe how you believe your child has been feeling lately:
 sad anxious depressed frightened guilty angry ashamed aggressive resentful
 worthless tearful irritable confused extreme ups / downs jealous hopeless helpless

Describe any behaviors your child has demonstrated that cause concern: _____

Has your child had any change in sleeping habits? Yes () No () Describe: _____

Has your child had any change in eating habits? Yes () No () Describe: _____

Has your child ever considered suicide in connection with his / her **current** problem? Yes () No ()

Has your child **attempted suicide recently** or in the **past**? Yes () No ()

If so, please give a brief description with dates: _____

Has your child tried to hurt others or animals recently in the past? Yes () No ()

If yes, please explain: _____

Please describe what activities your child participates in: _____

Who is in your child's support network?: _____

CULTURAL / ETHNIC / RACIAL BACKGROUND

What is the ethnic/racial group of the parents? (Hispanic, African American, etc.)

Does the child identify with this same group or another? Yes () No ()

Please explain: _____

SCHOOL ADJUSTMENT

School District: _____ School: _____

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

Present Grade: _____ Repeated 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) _____

Please describe your child's level of physical activity? _____

How much time does your child play on the computer, watch TV, or play video games: _____

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

PERSONAL ADJUSTMENT

How does the child relate to: Mother? _____ Father? _____

A Step-Parent? _____ Their Siblings? _____

Authority Figures? _____

Does your child experience any developmental, academic or behavioral problems while in school or daycare, with peers or teachers?

Yes () No () If yes, please explain: _____

Does your child consider anyone else to be a "parent" in his/her life? YES () NO () If so, whom? _____

Describe your relationship with your child:

Currently: _____

In the past: _____

HEALTH QUESTIONNAIRE

Height: _____

Weight: _____

Now	Past	NEUROLOGICAL	Now	Past	BLOOD
		Stroke ADD or ADHD Headaches Seizures Injury Sleep Disturbance Dizziness Fainting Tics			Disease AIDS Anemia Venereal Disease Mononucleosis Hepatitis
		DIGESTION			OTHER
		Stomach Pain Constipation Diarrhea Diabetes Frequent Urination Bed Wetting Overeating Under eating Vomiting Nausea Bleeding Food Allergies			Heart Disease Drug Abuse Alcoholism Pain Disorder Cancer Kidney Disease Thyroid Disorder Tobacco Use/Abuse Physical Disorders/ Disabilities Please Specify:
		RESIRATORY			SPECIAL SENSES
		Asthma Allergies Bronchitis Pain Pneumonia			Hearing Disorder Visual Disorder Speech Disorder

Current medications being taken:

- 1) _____ Dosage / Freq _____ Start Date: _____ Purpose: _____
- 2) _____ Dosage / Freq _____ Start Date: _____ Purpose: _____
- 3) _____ Dosage / Freq _____ Start Date: _____ Purpose: _____
- 4) _____ Dosage / Freq _____ Start Date: _____ Purpose: _____

Prescribed by: _____

Medication Allergies: _____

Has your child ever been hospitalized for medical or psychiatric reasons? Yes () No ()

Hospital	Month / Year	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any important medical history, chronic ailments, or other health problems your child experiences: _____

Present Medications that do not need a prescription: _____

If taking medications how do you feel they are working for child? _____

Does your child have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: _____

Describe any other health problems or important medical history about your child's immediate family members and close relatives, including chronic ailments: _____

COUNSELING/PRIOR TREATMENT HISTORY

Have you had psychotherapy/counseling before? [] Yes [] No If 'Yes' Where:

NAME OF CENTER	DATES ATTENDED
1. _____	_____

Type of service: [] Outpatient [] Inpatient [] Day Treatment

Was this for alcohol or other drug use? [] Yes [] No

Why did you stop going to therapy? _____

NAME OF CENTER

DATES ATTENDED

2. _____

Type of service: Outpatient Inpatient Day Treatment

Was this for alcohol or other drug use? Yes No

Why did you stop going to therapy? _____

CHEMICAL USE HISTORY (As Applicable)

Please check any of the following risk-taking behaviors you have engaged in:

- street racing gang involvement skip school dropped out dangerous dieting cutting stealing
- unprotected sex running away bullying others fire starting hurt animals over exercise
- restrict or restricted food intake

Please check any of the following alcohol /drugs that you currently or have previously used:

- LSD Spice beer wine hard liquor pot cocaine heroin Ecstasy speed
- over the counter drugs prescription drugs ice Triple C's dones quad bars Special K

SUBSTANCE	METHOD OF USE AMOUNT	AGE OF FIRST USE	AGE OF REG USE	AGE OF LAST USE	USED IN LAST 48 HRS	USED IN LAST 30 DAYS
Alcohol						
Barbiturates						
Valium/Librium						
Cocaine/Crack						
Heroin/Opiates						
Marijuana						
PCP/LSC/Mesc.						
Inhalants						
Caffeine						
Nicotine						
Over-Counter						
RX Drugs						
Other Drugs						

SUBSTANCE PREFERENCE

1. _____ 2. _____

Describe when and where you typically use _____

Describe any changes in your use patterns: _____

Do you use to build up your confidence? Yes No

Describe who or what has helped you: _____

Who in your family (present/past) has had a problem with drugs or alcohol? _____

Have you had withdrawal symptoms when trying to stop drinking/using? Yes No

Does your temperament change when you drink/use? (describe): _____

Has Alcohol/drugs created a problem for your job? Yes No

If 'Yes' describe: _____

PRESENT HEALTH

Physician: _____ Phone Number: _____

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 a hearing exam? _____ Results: _____

Has your daughter begun menstruation? _____ Age at onset? _____

What is your child's present health? _____

Past Health Problems: Hospitalizations, Accidents, Abortion, or a Handicap? _____

BIRTH AND DEVELOPMENT

Pregnancy: Normal? _____ Complications? _____ Explain: _____

Length of Labor: _____ Premature? _____ weeks Weight _____

Newborn's Health _____

Infancy: Any Problem Areas?

- | | |
|---|--|
| <input type="checkbox"/> Colic | <input type="checkbox"/> Fussy |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Cried Often |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Milk or Food Allergies | <input type="checkbox"/> Chronic Illness |
| <input type="checkbox"/> Sleep Patterning | <input type="checkbox"/> High Fevers |
| <input type="checkbox"/> Overactive | <input type="checkbox"/> Hospitalization |
| <input type="checkbox"/> Underactive | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Infections | <input type="checkbox"/> Slow Growth |

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 _____ months Knew numbers at _____ months. Knew letters at _____ months

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 a divorce or custody issue? _____

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

FAMILY INCOME INFORMATION

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

Family's Yearly Income? _____ Financial Difficulties? _____

YOUR SIGNATURE: _____ **DATE:** _____

STAFF USE ONLY

Therapist Signature _____ Date _____

M.D./D.O. Comments: _____

Physical Exam: is required is not required

Physician Signature _____ Date _____