***Sage Tree Psychology Group LLC***

 **Child/Adolescent History**

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Form completed by (if someone other than client) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_

May the agency/therapist contact you at home? Yes \_\_\_ No \_\_\_ Work? Yes\_\_\_ No \_\_\_

Why are you requesting counseling? When did these issues start?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptom Checklist:** (check all that apply)

|  |  |  |
| --- | --- | --- |
| Anger Anxious Appetite changes Bedwetting Compulsive behaviors Delusions Depressed mood Difficulty adjusting to life changes Difficulty concentrating Distinctive behaviors Fire-setting  | Flashbacks Hallucinations Hopelessness Hyperactivity Impulse control Lack of interest in activities Legal problems Loss/Grief Mania Nightmares/Night terrors Obsessive thoughts Oppositional behaviors  | Panic attacks Phobias Sexual difficulties Sleep related disorders Past substance use/abuse Current substance use/abuse Suicidal/Homicidal ideations Tearful Weight changes Worrisome Other  |

If you have other symptoms not listed above, please describe.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Have any of the above symptoms been present for more than a year?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 What improvements would you like to see?

Peers:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COUNSELING AND PRIOR TREATMENT**

Please list all previous treatment experiences.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Type of Treatment**  | **Yes**  | **No**  | **Date (month/year)**  | **# Of times**  | **Where**  | **Outcomes**  |
| Counseling/Psychiatric Treatment  |    |   |    |   |   |    |
|  Alcohol/Drug Treatment  |    |   |    |   |   |    |
|  Hospitalizations   |    |   |    |   |   |    |
|  Self-help groups: AA, Al-Anon, ACOA, Overeaters, Other(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |    |   |    |   |   |    |

 **Have you experienced any of the following?**

|  |  |
| --- | --- |
|     Physical Abuse  |    Problems in school  |
|     Sexual Abuse  |    Trauma from crime  |
|     Emotional Abuse  |    Emotional difficulty due to divorce  |
|     Neglect  |    Sibling conflicts  |
|     Protective Service Involvement  |    Parenting problems  |
|     Severe childhood illnesses   |    Physical / Domestic violence  |
|   |  |

Have you ever experienced any suicidal thoughts? Yes  No  Current Past Age:\_\_\_\_\_ If yes, please describe; and if they are current, please provide some details.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever attempted suicide? Yes  No  Current Past Age:\_\_\_\_\_\_ If yes, list how many times, the most recent date, and the method (s) used.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced any homicidal thoughts? Yes  No  Current Past Age:\_\_\_\_\_\_

If yes, please describe; and if they are current, please provide some details.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever acted on these thoughts? Yes  No 

If yes, list how many times, the most recent date, and the method (s) used.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever assaulted anyone? Yes  No 

If yes, list how many times, and include the dates and how the assault(s) happened.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has a family member or close friend of yours ever attempted or committed suicide? Yes  No 

Family Member or Friend Attempted / Committed When / Age

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICAL & MEDICAL HISTORY**

Last physical exam: Date: \_\_\_\_\_\_\_\_\_Perfomed by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Personal Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any history of head injuries?  Yes  No If yes, at what age: \_\_\_\_\_\_\_\_\_\_\_

Are you pregnant?  Yes  No If Yes, when is your expected due date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your health? Excellent Good Fair Poor 

Have you ever had any seizures?  Yes  No If Yes, when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had surgery?  Yes  No If Yes, when:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have access to medical insurance?  Yes  No

I currently receive treatment for physical symptoms, pain, and/or an impairment or disability. Yes  No

|  |  |
| --- | --- |
| Please list any past or present illnesses or medical conditions  | Are you currently being treated?  |
| (Type of Illness or Condition)  |  YES  | NO  |
|    |    |   |
|    |    |   |
|    |    |   |
|   |   |  |
|    |    |   |

Do you have any known drug or other allergies?  Yes  No

If Yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced or been treated for any of the following problems? Yes  No

|  |  |
| --- | --- |
|   |  |
|  Blackouts   |  Heart Disease  Thyroid Problems  |
|   Cancer  |  High or Low Blood Pressure  Seizures  |
|  Migraines   |  Kidney Disease  TB  |
|  Diabetes   |  Liver Disease  Weight Changes  |
|  DT’s   |  Pancreatis  Other  |

If Other, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list your current medications, including over the counter (OTC) medications.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication**  | **Dosage**  | **RX Date**  | **Doctor**  | **Reason**  |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |

Is there any family history of medical issues?  Yes  No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **FAMILY INFORMATION**  |  |  |  |
|   |  Name  |  Current Age  | Deceased  | Your age then  | Living with you |
| Yes  | No  | Yes  | No  |
| Mother  |   |   |   |   |   |   |   |
| Father  |   |   |   |   |   |   |   |
| Spouse  |   |   |   |   |   |   |   |
| Children  |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |
| Siblings  |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |

 Please list anyone else living with you.

|  |  |  |
| --- | --- | --- |
|    | Age  | Relationship to you  |
|    |   |   |
|    |   |   |

**Parental Information:**

* Parents legally married: how long \_\_\_\_\_  Mother remarried: your age \_\_\_\_\_
* Parents ever separated: your age \_\_\_\_\_  Father remarried: your age \_\_\_\_\_
* Parents ever divorced: your age \_\_\_\_\_  I was adopted and/or placed in foster homes.

 , your age \_\_\_\_\_

Do you have any conflicts with family members? Yes No

If Yes, Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your current relationships with family:  Good  Fair  Poor

Please list any other family information that your therapist may find helpful in treating you. For example, were you raised outside the home by grandparents, other family members, or foster homes, etc?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe how you relate to other people (e.g., easily, shy, leader, follower, outgoing, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who are the (3) people you feel closest to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wish to have any family members or close friends involved in your treatment? Yes  No

Assessment of current relationship:  Good  Fair  Poor  N/A

Has anyone in your family ever been diagnosed with a mental illness? Yes  No 

|  |  |  |
| --- | --- | --- |
| **Family Member**  | **Type of Illness**  | **When**  |
|   |    |    |
|    |    |    |

 **RECREATION & LEISURE**

Has your activity level changed in the last 6 months? Yes  No 

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Which of the following activities do you participate in on a regular basis?

**Daily/ Weekly/ Monthly** **Daily/ Weekly/ Monthly**

*   Art    Books/Films
*   Music    Physical fitness
*   Crafts    Diet/Health
*   Outdoor activity    Sports
*   Church activity    Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you or any family member have a gambling problem? Yes  No 

Do you ever gamble more than you intended? Yes  No 

If yes please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **SPIRITUAL & RELIGIOUS MATTERS**

If yes to the above what religion were you raised in and what religion to you practice now?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you have any spiritual/religious issues that may affect your treatment? Yes  No 

If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CULTURAL / ETHNIC INFORMATION**

What is your cultural or ethnic background? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your cultural or ethnic background a significant part of your life? Yes  No 

If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have any concerns how your culture or ethnicity may affect your therapy? Yes  No 

If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  **SUPPORTS / STRENGHTS / SOCIAL**

Who do you feel you can look to for support? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you were in need of help, or needed to talk to someone, who would you turn to?

Do you feel that family members support each other? Yes  No 

If no, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe how you relate to other people (e.g., easily, shy, leader, follower, outgoing, etc.)

Please list your strengths: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who are the (3) people you feel closest to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do your social activities include the use of drugs or alcohol? Yes  No If yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sexual Orientation:**

\_\_\_ Heterosexual (attracted to opposite sex) \_\_\_ Bisexual (attracted to both sexes)

\_\_\_ Homosexual (attracted to the same sex) \_\_\_ Not sure

\_\_\_\_Transgender

Do you have concerns about your sexuality that you would like to discuss with your therapist? Yes  No 

If yes, please explain.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EDUCATION**

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Did your child attend a pre-school or day-care program? Yes  No 

When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long did he or she attend? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where does your child attend school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teacher’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade\_\_\_\_\_\_\_Current grade average (A-F)\_\_\_\_\_\_\_\_\_\_ Any recent changes? \_\_\_\_\_\_  Up  Down

Were any grades repeated? Yes  No  If Yes, what grade (s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever had special tutoring? Yes  No  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever attended special education classes? Yes  No  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your child’s relationship to his/her teacher(s)? Excellent Good Fair Poor

Has your child ever been suspended/expelled from school? Yes  No 

When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many different schools has your child attended? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your child’s behavior in school?  Excellent  Good  Fair  Poor

 **LEGAL**

Have you been referred by Court Order? Yes  No 

Name & Address of court (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been, or are you now involved in any of the following legal or court proceedings?

|  |  |  |  |
| --- | --- | --- | --- |
| Drunk Driving  | Yes  No   |  Currently on Probation/Parole  | Yes  No   |
| Assault Crime  | Yes  No   |  Civil Case  | Yes  No   |
| Workman’s Comp  | Yes  No   |  Juvenile Court  | Yes  No   |
| Bankruptcy  | Yes  No   |  DHS  | Yes  No   |

If yes please complete the following:

|  |  |  |  |
| --- | --- | --- | --- |
| Type of Case, charge, arrest, etc.   | Date   | Where (city)  | Result  |
|    |    |   |   |
|    |    |   |   |
|  |  |  |  |

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 **COMPULSIVE BEHAVIOR**

Have you experienced any of the following behaviors that you would consider compulsive or addictive.

|  |  |  |
| --- | --- | --- |
|  Cleaning  |  Internet  |  Shopping  |
|  Eating  |  Pornography  |  Work  |
|  Gambling  |  Sex  |  Other  |

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**Comments:**

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 **CHEMICAL USE HISTORY**

Has your child’s social activities included the use of drugs or alcohol? Yes  No 

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you suspect a drug/alcohol problem? Yes  No

What is the drug of choice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When was a substance last used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much is, or was being used? \_\_\_\_\_\_\_\_\_\_\_\_ Longest period of abstinence? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please complete the following table as it relates to your child.**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Child’s Current Age \_\_\_\_\_\_\_\_\_\_  | Age of first use   | Age of last use  |   | Method of use   |  |  Amount  |  How Often?  | Used in last 48 hours  | Used in the last 30 days  |
| Oral  |  Injection | Smoke | Inhale |  Yes  |  No | Yes | No |
|  Caffeine  |    |    |    |    |   |   |   |   |    |    |   |   |
|  Nicotine  |    |    |    |    |   |   |   |   |    |    |   |   |
|  Alcohol  |    |    |    |    |   |   |   |   |    |    |   |   |
|  Barbiturates  |    |    |    |    |   |   |   |   |    |    |   |   |
|  Valium / Librium  |    |    |    |    |   |   |   |   |    |    |   |   |
|  Cocaine/Crack  |    |    |    |    |   |   |   |   |    |    |   |   |
|  Heroin/Opiates  |    |    |    |    |   |   |   |   |    |    |   |   |
|  Marijuana  |    |    |    |    |   |   |   |   |    |    |   |   |
|  PCP  |    |    |    |    |   |   |   |   |    |    |   |   |
|  LSD  |    |    |    |    |   |   |   |   |    |    |   |   |
|  Mescaline  |    |    |    |    |   |   |   |   |    |    |   |   |
|  Inhalants  |    |    |    |    |   |   |   |   |    |    |   |   |
|  Ecstasy  |    |    |    |    |   |   |   |   |    |    |   |   |
|  Crank/Ice  |    |    |    |    |   |   |   |   |    |    |   |   |
|  Other  |    |    |    |    |   |   |   |   |    |    |   |   |

|  |  |
| --- | --- |
| **Please check all that may apply to your child.**  Drinking/drug use before school  |  Skipping class to get high  |
|  Family/friends concerned about use  |  Using during school hours  |
| * Nervousness  Depression
* Mood Swings  Binge use
* Found evidence of alcohol/drug use at home
 |   Behavior changes  |

Do any of your family members have a drug or alcohol problem? Yes  No 

If so, whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like more information regarding the prevention of alcohol & drug use/abuse? Yes  No 

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**NUTRITIONAL PATTERNS**

Height:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you on a special Diet? Yes  No  What kind \_\_\_\_\_\_\_\_\_\_\_Why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last time you exercised? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you eat less then three meals per day? Yes  No 

Do you binge eat? Yes  No 

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your weight changed by more then 10 pounds in the past year? Yes  No Up Down 

If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any concerns about your eating patterns? Yes  No 

If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **BIRTH / DEVELOPMENT INFORMATION**

**Birth History:**

* Normal Pregnancy  Premature labor and delivery  Normal APGAR scores at birth
* Normal labor and delivery Trauma/illness during pregnancy  Post-natal respiratory difficulties
* Born with Disability  Limited or no prenatal care  Post-natal motor difficilties
* Routine prenatal care  Substance use during pregnancy  Extended hospital stay

**Were there any other post-natal difficulties:** Yes  No 

If yes, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Did child go home with mother from hospital?** Yes  No 

**My child reached their developmental milestones at the correct age?** Yes  No 

|  |  |
| --- | --- |
| **Question (please answer the following questions to the best of you ability) At what age did your child achieve the following?**  | **Age**  |
| **Hold their head held erect and steady.**  |  |
| **Roll Over**  |  |

|  |  |
| --- | --- |
| **Sitting Up**  |  |
| **Crawling**  |  |
| **Walking**  |  |
| **First Words**  |  |
| **Sentences**  |  |
| **Toilet-trained - day**  |  |
| **Toilet-trained - night**  |  |

**Medical History**

|  |  |  |
| --- | --- | --- |
| **Question (please answer the following questions to the best of you ability) Has your child ever experienced any of the following?**  | **Yes**  | **No**  |
|  |  |
| **Head Injury or trauma**  |  |  |
| **Hyperactivity**  |  |  |
| **Hypoactivity**  |  |  |
| **Headaches**  |  |  |
| **Significant Injury**  |  |  |
| **Seizures**  |  |  |
| **Hospitalization**  |  |  |
| **Significant Illness**  |  |  |
| **Surgery**  |  |  |
| **Hearing problems**  |  |  |
| **Vision problems**  |  |  |
| **Speech problems**  |  |  |

**Are your child’s immunization records up to date?** Yes  No 

**MMR:** Yes  No Age: \_\_\_\_\_\_ **Tetanus:** Yes  No Age: \_\_\_\_\_\_

**Poliomyelitis:** Yes  No Age: \_\_\_\_\_\_ **Whooping Cough:** Yes  No Age: \_\_\_\_\_\_ **Smallpox:** Yes  No Age: \_\_\_\_\_\_

**SOCIAL**

**Peer Relations**

**How would you describe your child’s relationship with peers?**

|  |  |
| --- | --- |
|   Appropriate  Aggressive  |  Leader  |
|   Conflictual  Violent  |  Gang Association  |
| * Bossy  Argumentative
* Passive  Follower

 **Relationships with Adults or Authority Figures**  |  Other  |
|   Appropriate  Passive  |  Leader  |
|   Conflictual  Aggressive  |  Gang Association  |
|   Isolated  Violent  |  Loner  |
| * Withdrawn  Argumentative
* Bossy  Follower
 |  Other  |

**If other, Please comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is the Child or adolescent sexually active? (as reported by client):**

 Yes No  Refused to answer

**Has the child ever been alleged, suspected, or charged w/behavior of a sexual nature?**

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|  |  |  |
| --- | --- | --- |
|  None  |  Fondling  |  Rape  |
|  Peeping  |  Oral Sex/Sodomy  |  Other  |
|  Inappropriate Touching  |  Intercourse  |  |

**If other, Please comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has your child ever received Psychological Testing?**  Yes No

When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature/Credentials Date

**ADDITIONAL INFORMATION**

Is there anything else that you feel is important for your therapist to know about? If yes, please comment in the space provided and on the back if you need more room, thank you.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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