A NEW DAY COUNSELING CENTER
Western Seminary
5511 SE Hawthorne Blvd.
Portland, OR 97215
Phone: 786-A-NEW-DAY

Child/Adolescent Personal History Information

Name of Child/Adolescent:_____
First Middle Last

Sex:_____ Current Age:_____ Birthdate:____-_____-_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Is it okay to leave a message at: home? _____ cell? _____ work? _____

Address:_____

City:_____State:_____Zip:_____

Name and relationship of person bringing in client:_____

Referred by:_____Relationship:_____

Name of client's parents:_____

Parent's marital status: Never married Engaged Married Divorced Separated
Living Together Remarried Widowed

Parent's occupations:_____

In case of emergency contact:_____

Phone:_____Relationship:_____

Religious affiliation and/or preferred church, mosque, or place of gathering:_____

People who currently live in child/adolescent's household:

Name	Sex	Age	Relationship

For Office Use Only:

_____ _____ ☐ Individual ☐ Family ☐ Group
Date of Term Name of Counselor

_____ _____ ☐ Individual ☐ Family ☐ Group
Date of Term Name of Counselor

See also: _____

Name of Client: _____

Significant individuals or family members not currently living with child/adolescent:

Name	Sex	Age	Relationship

Reasons for seeking help at this time:

Who else is aware of your problem (s)?

Describe any circumstances, which may be impacting your concerns:

Has your child/adolescent ever been in counseling, psychotherapy, or treatment? If so, when? Was it helpful?

Has your child/adolescent ever attempted suicide? If so, please give details.

What would your child/adolescent or yourself like as a result of counseling?

Please check each item which is a concern to you or your child/adolescent about him/her:

___Appetite/weight
___Bowel problems
___Depression
___Energy
___Inferiority
___Work
___Concentration
___Anger
___Nervousness
___Legal matters
___Nightmares
___Alcohol use
___Separation

___Stomach aches
___Headaches
___Loneliness
___Unhappiness
___Shyness
___Discipline
___Education
___Temper
___Stress
___Finances
___Dreams
___Thoughts
___Marriage

___Health Problems
___Sleep-too little/much
___Suicidal thoughts
___Tiredness
___Making decisions
___Ambition-little/much
___Relaxation-little/much
___Self-control
___Fears
___Friends
___Memories
___Drug use
___Sexual problems

___Other: _____

Health and Developmental History

Overall health condition of child/adolescent: very good good average poor

Height: _____ Weight: _____ Recent weight gain or loss: _____

Last physical exam: _____ Report:_____

Physician's name, address, and phone number: _____

_____

List any childhood diseases: _____

List any allergies: _____

Any prolonged fever of more than 103 degrees? _____

Convulsions, fainting, breathing problems, or loss of balance: _____

_____

Head injuries: _____

_____

Hospitalizations: _____

_____

Medications currently taking: _____

_____

Past medications including any adverse effects: _____

_____

Please check all that apply to your child/adolescent:

___Anorexia/bulimia
___Back pain
___Blackouts
___Burning/itchy skin
___Chest pains
___Constipation
___Diarrhea
___Dizziness
___Don't like to be touched
___Dry mouth
___Excessive sweating
___Fainting spells
___Fatigue
___Headaches
___Hearing problems
___Indigestion
___Muscle spasms
___Nausea
___Overeating
___Palpitations
___Poor appetite
___Rapid heart beat
___Sexual problems
___Skin problems
___Sleeping too much
___Sleeplessness
___Stomach Problems
___Tension
___Tics
___Tingling
___Tremors
___Twitches
___Unable to relax
___Visual disturbances
___Vomiting
___Watery eyes
___Weight loss
___Weight gain
___Flushes

Was the pregnancy planned or unplanned? _____

During the pregnancy was there any bleeding, infections, medications, or vomiting?

_____

During the pregnancy was there emotional stress, blood pressure elevation, or substance abuse?

_____

How close to the due date was the baby born? _____

Birth weight :_____ Length:_____ Head circumference:_____

Length of labor:_____

Normal, breech or caesarian section delivery:_____

Anything unusual such as cord around neck, breathing difficulties: _____

_____

As a baby, were there any frequent illnesses (i.e. colds, vomiting, diarrhea, dehydration)?

_____

Was he/she a "good baby"? Why or why not? _____

_____

Developmental Periods: (give age)

_____ crawled	_____ walked alone	_____ toilet trained
_____ pedal tricycle	_____ bedwetting	_____ watch tv
_____ first word	_____ first sentence	_____ spoke clearly
_____ skip	_____ color	_____ use scissors

Does/did your child/adolescent fear being separated from you? _____

Does your child/adolescent follow instructions from parents? _____

How long and how well does your child/adolescent sleep? _____

Client's life in general: (circle one) very happy happy average unhappy very unhappy

Client's life in last 6 months: (circle one) very happy happy average unhappy very unhappy

What is your child/adolescent's greatest fear: _____

_____

What is your child/adolescent's greatest hope: _____

_____

Personality of Child/Adolescent: (Circle items that are applicable)

tense relaxed restless calm daydreamer self starter active sluggish

stubborn eager to please easy to manage disobedient happy sad angry

loving aloof friendly secure easily frightened bold cautious whining

generous jealous cruel aggressive affectionate relates easily to adults

relates poorly to adults attached to certain toys/objects to point of not being able to leave at home

Have there been noticeable changes in behavior or personality at any time in his/her life?

How many moves has family made and what was age of child/adolescent at each move?

Does your child/adolescent ever have hallucinations?

Does your child/adolescent ever complain of hearing voices that others do not hear?

Does your child/adolescent have any overwhelming fears?

Check any concerns regarding your child/adolescent:

___Abuse, physical
___Allergies
___Anger
___Arguing
___Attentivenss
___Bad dreams
___Bed wetting
___Complaining
___Depression
___Disobedience
___Drugs/Alcohol
___Fighting
___Friendships
___Health
___Hyperactive
___Immaturity
___Impulsive
___Jealousy
___Lying
___Moods
___Running away
___School
___Sexual abuse
___Sexual concerns
___Shyness
___Sleep
___Stealing
___Spouse/Ex interferes
___Swearing
___Temper tantrums
___Unhappiness
___Visitation arrangement
___Worrying/fears

___Other: _____

School History

Name of school child/adolescent attending:

Grade:

Average grade point:

Has your child/adolescent ‘s behavior ever been a concern of one of his/her teachers? If so, please describe:

Does your child/adolescent have any difficulties learning?

Did your child/adolescent have any difficulty in writing, such as reversals, poor coordination, memory of letters or numbers, etc.?

Did child/adolescent have any difficulty with reading or arithmetic? If so, please describe.

What are your child/adolescent’s strengths in school?

Legal History

Is child/adolescent currently on probation or parole: yes/no If yes, please give end date and list name of a contact person?

Are any family members currently on probation or parole: yes/no If yes, please comment.

Family History

Please list anyone in child/adolescent’s family, including child/adolescent and extended family, who used or uses alcohol or drugs (prescription or street drugs)

relationship to child types of drugs purpose for how long

_____

_____

_____

_____

Describe for each parent the quality of home life (i.e. happy, tense, communication, relations with children, stability, security, religious commitment, etc.)

_____

_____

Describe your marriage relationship (i.e. how well you get along, communication, agreement on discipline of children, etc.)

_____

_____

Did either parent have similar characteristics or problems as does the child/adolescent?

_____

_____

How does the child/adolescent get along with others in the family and neighborhood?

_____

_____

Please describe in detail the reason for having this child seen professionally.

Indicate the age the problem began and probable causes
What has made the problem better or worse?
Describe feelings and moods observed
Are there problems regarding play and recreation?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please list any concerns you may have about your child/adolescent beginning counseling:

_____

_____

_____