Schwartz
Therapy + Wellness, P.C.
small steps every day

CHILD/ ADOLESCENT PERSONAL HISTORY (Ages 17 + Under)

TO BE FILLED OUT BY PARENT OR GUARDIAN. THE INFORMATION THAT YOU PROVIDE TO US WILL BE VERY HELPFUL IN TREATING YOUR CHILD. PLEASE FILL OUT COMPLETELY. IF YOU HAVE DIFFICULTY WITH ANY OF THE QUESTIONS, YOUR CHILD'S THERAPIST WILL REVIEW THEM WITH YOU. THANK YOU!

CLIENT NAME: ______________________________________ AGE: ________ DATE: _____________

Person completing form for client: ______________________ Relationship to Client: ___________

	FULL NAME	AGE	LIVING IN THE HOME?	IF DECEASED, YEAR + CAUSE
CHILD'S MOTHER				
CHILD'S FATHER				
STEP MOTHER				
STEP FATHER				
BROTHERS +SISTERS (INCLUDE STEP + HALF)				
Who else lives with you other than the ones checked above?				

Child was raised by? ____

PROBLEM

Describe the problems that the child is having (behaviors, feelings, attitudes, school performance, etc.) ____

What is the main problem that you are bringing the child for? ______________________

How long has he/she been having these problems? _____________________________

Why do you think the child is having these problems? ___________________________

Whose idea was it to have the child brought to this practice for help? ______________

What would you or they like to see done for the child? ___________________________

Describe how the child's problems affect you, other family members and others: ________

____

SYMPTOMS (CHECK ALL THE ITEMS THAT YOU BELIEVE FIT THIS CHILD)

- o Speech difficulties
- o Nervous habits/ behavior
- o Frequent headaches
- o Frequent stomach-aches
- o Sleep disturbance
- o Difficulty making friends
- o Difficulty keeping friends
- o Little interest in friends
- o Little interest in activities
- o Disrespectful/argumentative
- o Temper tantrums
- o Ignores rules/ chores
- o Defies authority
- o Threatening behavior
- o Throws/breaks things
- o Gets in frequent fights
- o Hurts animals
- o Sets fires
- o Steals
- o Lacks guilt/remorse
- o Lies a lot
- o Breaks curfew often
- o Runs away
- o Skips school
- o Doesn't complete schoolwork
- o Has problematic friends
- o Underactive
- o Acts before thinking
- o Short attention-span
- o Unable to sit still
- o Clowns a lot
- o Accident-prone
- o Sucks thumb
- o Wets the bed
- o Wets/ soils clothes
- o Bangs head
- o Grinds teeth
- o Separation problems
- o Worries a lot
- o Afraid/ fearful
- o Seems insecure
- o Withdrawn
- o Shy
- o Sad/ depressed
- o Cries frequently
- o Won't sleep in own bed
- o Seems too serious
- o Secretive
- o Looks "high" often

***Continued*, SYMPTOMS (CHECK ALL THE ITEMS THAT YOU BELIEVE FIT THIS**

- o Keeps to him/herself
- o Avoids family activities
- o In his/her own world
- o Imaginary friends
- o Unusual behavior
- o Mentally slow
- o Nightmares
- o Acts spoiled
- o Too interested in sex
- o Disorganized/ messy
- o Other: ________________
- o Other: ________________

Please explain each item that you checked (you may also write on the back of this page):

____

____

____

Has the child ever expressed a wish that he/ she were dead? _______ How recently? ________

Has the child ever threatened or attempted to seriously harm self or others? ________________

Please explain: ____

INTERESTS/ ACTIVITIES (CHECK ALL THAT APPLY)

- o Watch television
- o Movies/ videos
- o Play video games
- o Listen to music
- o Talk on the phone
- o Play sports
- o Ride bicycle
- o Play on the computer
- o Rollerblade
- o Build things
- o Collect things
- o Paint
- o Draw
- o Read
- o Sing
- o Dance
- o Skate
- o Write
- o Scouting
- o School
- o Crafts
- o Baby-sit
- o Imaginary play
- o Action figures
- o Dolls
- o Social media
- o Sew/ knit
- o Other: _____________
- o Other: _____________

Has the child lost interest in activities that he/ she normally enjoyed? _________________________

EMPLOYMENT

Where does the child work? ____

Employment/ training/ work hours of each parent or guardian:

You: ____

Your spouse/ partner: ____

LEGAL HISTORY

Describe any legal problems that the child has had in past or present: ______________________

____

EDUCATION

Name of school: ____ Grade: ___________

School Address: ____ Phone: _________________

Teacher: ____ Counselor: ____________________________

Is the child in any special classes? __________________________ Since what grade? ___________

Does the child have any Learning Disabilities? ____

Has the child repeated any grades? ____________________________ What ones? _____________

Describe child's attendance: ____

Describe effort/ attitude toward school: ____

Describe child's *behavior* in school: ____

Describe academic performance: ____

When did school behavior and/ or academic performance change? ______________________

Education of each parent or guardian: ____

ETHNIC/ CULTURAL

Background (Child's): ____

RELIGIOUS/ SPIRITUAL

Background (Child's): ____

SEXUAL/ GENDER ISSUES

Describe any sexual or gender concerns you have about the child: _______________________

PREVIOUS MENTAL HEALTH OR ALCOHOL/ SUBSTANCE ABUSE TREATMENT:

OUTPATIENT: Has the child seen a therapist or counselor for personal or family problems or alcohol/ drug treatment? ____

Continued: PREVIOUS MENTAL HEALTH OR ALCOHOL/ SUBSTANCE ABUSE TREATMENT:

When, where? ____

Reason: ____

INPATIENT: Has the child been in a hospital or Residential treatment for personal or family problems or alcohol/ drug treatment? ____

When, where? ____

Reason: ____

Where any of the child's treatment experiences helpful? _____________________________

What medications was the child prescribed for emotional or behavioral problems? ________

____

List any of the child relatives (parents, grandparents, aunts, uncles, cousins, brothers, sisters) who have been hospitalized for personal or substance abuse problems:

Who, when, where? ____

____

PHYSICAL HEALTH

Child's Physician Name: ______________________________

Physician's Address: _____________________________________ Phone: ______________

Date child last saw Physician: ____________________ Reason: ________________________

Results of Physician visit/ tests: ____

Medications child is on; ____

Immunizations up to date? ____

Child's Height: __________ Weight: __________ Appetite: __________

Recent weight gain? ________ Loss? ____________ Does child over- eat? ______________

Binge? ___________ Purge? ____________ Energy/ activity level: ____________________

Food or medication allergies: ____

If child has had any serious illnesses, injuries, or surgeries or medical hospitalizations, please explain: ____

DEVELOPMENTAL HISTORY

Was this pregnancy desired? ____________________ Length of term: _______________

Problems/ complications during pregnancy: ____

Did mother smoke, drink, use drugs during pregnancy? ___________________________________

Problems/ complications during delivery: ____

Explain if mother and child were separated after birth: ___________________________________

Other mother/ child separations: ____

Describe the child as an infant/ toddler (happy, fussy, overactive, withdrawn, etc.)

____

Age child sat up: _______________ Took steps: __________ Spoke words: ______________

Spoke in sentences: ___________________ Age child was weaned: ___________________

Began feeding self: _____________ Age that child was toilet- trained during the day: ________

During the night: ________ Problem now: ____________ Age that child dressed self: _________

Age child tied own shoe- laces: _____________ Age that child rode a 2-wheel bike: _________

FAMILY RELATIONSHIPS

How do you get along with your child? ____

If one or both of child's parents are out of the home, describe each one's current relationship with the child: Father: _________________________ Mother: ____________________

How does the child get along with brothers + sisters? _____________________________________

RULES/ RESPONSIBILITIES/ RELATIONSHIPS

How does the child deal with rules, responsibilities, and chores? __________________________

Does the child obey curfew? ______________________ Has the child threatened/ attempted to run away or stay out all night? ____

How do you deal with the child's misbehavior? ____

Do you or your spouse/ partner believe in physical discipline? ____________________________

Has the family ever been involved with Protective Services? _____________________________

Are there any situations at home that might have an effect on the child's behavior? ________

____

DRINKING/ DRUG USAGE (Please be as specific as possible for this section)

Do you have knowledge of or suspicion of your child using cigarettes/ e-cigarettes or vape products? If yes, please explain: ____

Do you have knowledge of or suspicion of your child getting high? If yes, please explain:

____

Do you have knowledge of or suspicion of your child drinking alcohol? If yes, please explain:

____

Do you drink, smoke or use drugs? ____

Do your children know? If yes, please explain: ___________________________________

ADDITIONAL INFORMATION

Do you have anything else to share at this time? If so, please use the space provided to provide additional information to your therapist: _____________________________

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