On Deck Counseling
Personal History—Children and Adolescents

Client's name: _____ Gender: F M Date of birth: _____ Age: _____
Form completed by: _____ Relationship: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone (home): _____ (work): _____ (Cell) _____
Preferred email: _____ Preferred phone: _____

Primary reason(s) for seeking services:

__ Anger management ____ Anxiety ____ Coping ____ Depression
__ Eating disorder ____ Fear/phobias ____ Mental confusion ____ Sexual concerns
__ Sleeping problems ____ Addictive behaviors ____ Alcohol/drugs ____ Hyperactivity
__ Other mental health concerns (specify): _____

Family History

With whom does the child live? _____
Are parent's divorced or separated? _____If Yes, who has legal custody? _____
Is there any significant information about the parents' relationship or treatment toward the child, which might be beneficial in counseling? ___ No _____ Yes Describe: _____

Child's Mother

Name: _____ Age: _____ Occupation: _____ ___ FT ___ PT
Where employed: _____ Work phone: _____ Cell:_____
Mother's education: _____
Is there anything notable, unusual or stressful about the child's relationship with the mother? __ No ___ Yes Explain:
_____
_____
How is the child disciplined by the mother? _____
For what reasons is the child disciplined by the mother?_____

Child's Father

Name: _____ Age: _____ Occupation: _____ ___ FT ___ PT
Where employed: _____ Work phone: _____ Cell:_____
Father's education: _____
Is there anything notable, unusual or stressful about the child's relationship with the father? _____ No _____ Yes Explain:
_____
_____
How is the child disciplined by the father? _____
For what reasons is the child disciplined by the father? _____

Child's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
_____	____	___F ___ M	_____ home _____away	_____ poor ____average ____good
_____	____	___F ___ M	_____ home _____away	_____ poor ____average ____good
_____	____	___F ___ M	_____ home _____away	_____ poor ____average ____good
_____	____	___F ___ M	_____ home _____away	_____ poor ____average ____good

Others living in the household/Relationship (e.g., cousin, foster child)

_____ ____ ___F ___ M _____ home _____away _____ poor ____average ____good
_____ ____ ___F ___ M _____ home _____away _____ poor ____average ____good
_____ ____ ___F ___ M _____ home _____away _____ poor ____average ____good
_____ ____ ___F ___ M _____ home _____away _____ poor ____average ____good

Comments: _____

Childhood/Adolescent History

Developmental History

Compared with others in the family, child's development was: ____ slow __ average __ fast

Injuries or hospitalization: _____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.) _____

_____

Education

Type of school: ____ Public __ Private ____ Home schooled ____ Other (specify): _____

Grade: _____ In special education? No Yes Describe: _____

In gifted program? Yes No Has child ever been held back in school? No Yes Has child been tested psychologically? Yes No

Which subjects does the child enjoy in school? _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? No Yes Describe: _____

Feelings about School Work:

__ Anxious ____ Passive ____ Enthusiastic ____ Fearful
__ Eager ____ No expression ____ Bored ____ Rebellious
__ Other (describe): _____

Approach to School Work:

__ Organized ____ Industrious ____ Responsible ____ Interested
__ Self-directed ____ No initiative ____ Refuses ____ Does only what is expected
__ Sloppy ____ Disorganized ____ Cooperative ____ Doesn't complete assignments
__ Other (describe): _____

Performance in School (Parent's Opinion): _____ Satisfactory _____ Underachiever _____ Overachiever

Other (describe): _____

Child's Peer Relationships:

__ Spontaneous ____ Follower ____ Leader ____ Difficulty making friends
__ Makes friends easily ____ Long-time friends ____ Shares easily
__ Other (describe): _____

Who handles responsibility for your child in the following areas?

School: ____ Mother __ Father Shared Other (specify):_____
Health: ____ Mother __ Father Shared Other (specify): _____
Problem behavior: ____ Mother __ Father Shared Other (specify):_____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, physical fitness, sports, outdoor activities, church activities, walking, exercising, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

Please check any of the following that your child has been treated for.

___ Abortion
___ Asthma
___ Blackouts
___ Bronchitis
___ Cerebral Palsy
___ Chicken Pox
___ Congenital problems
___ Croup
___ Diabetes
___ Diphtheria
___ Dizziness
___ Ear aches
___ Ear infections
___ Eczema
___ Encephalitis
___ Fevers
___ Hay fever
___ Heart trouble
___ Hepatitis
___ Hives
___ Influenza
___ Lead poisoning
___ Measles
___ Meningitis
___ Miscarriage
___ Multiple sclerosis
___ Mumps
___ Muscular Dystrophy
___ Nose bleeds
___ Other skin rashes
___ Paralysis
___ Pleurisy
___ Pneumonia
___ Polio
___ Pregnancy
___ Rheumatic Fever
___ Scarlet Fever
___ Seizures
___ Severe colds
___ Severe head injury
___ Sexually transmitted disease
___ Thyroid disorders
___ Vision problems
___ Wearing glasses
___ Whooping cough
___ Other _____

List any current health concerns:_____

_____

List any recent health or physical changes: _____

_____

Most recent medical examinations

Type of examination	Date of most recent visit	Results
Physical examination	_____	_____
Dental examination	_____	_____
Vision examination	_____	_____
Hearing examination	_____	_____

Medical Diagnosis: _____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Chemical Use History

Does the child use or have a problem with alcohol or drugs? No Yes Describe: _____

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

	Yes	No	When	Where	Reaction or overall experience
Counseling/Psychiatric care	____	____	_____	_____	_____
Suicidal thoughts/attempts	____	____	_____	_____	_____
Drug/alcohol treatment	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____

Behavioral/Emotional

How are problem behaviors generally handled? _____

What are the family's favorite activities? _____

What does the child/adolescent do with unstructured time? _____

Has the child/adolescent experienced death? (friends, family pets, other) ___ Yes ___ No At what age? _____
If Yes, describe the child's/adolescent's reaction: _____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.) No Yes If Yes, describe:
_____

Please check any of the following that are typical for your child:

___ Affectionate	___ Eating Disorder	___ Loner	___ Shy, Timid
___ Aggressive	___ Enthusiastic	___ Low Self-Esteem	___ Sleeping Problems
___ Angry	___ Expects Failure	___ Messy	___ Slow Moving
___ Anxiety	___ Fatigue	___ Moody	___ Soiling
___ Attachment to Dolls	___ Fearful	___ Nightmares	___ Speech Problems
___ Avoids Adults	___ Frequent Injuries	___ Obedient	___ Steals
___ Bedwetting	___ Frustrated Easily	___ Often Sick	___ Stomach Aches
___ Blinking, Jerking	___ Gambling	___ Oppositional	___ Suicidal Threats
___ Bullies, Threatens	___ Generous	___ Over Active	___ Suicidal Attempts
___ Careless, Reckless	___ Hallucinations	___ Overweight	___ Talks Back
___ Chest Pains	___ Head Banging	___ Panic Attacks	___ Teeth Grinding
___ Clumsy	___ Heart Problems	___ Phobias	___ Thumb Sucking
___ Confident	___ Hopelessness	___ Poor Appetite	___ Tics, Twitching
___ Cooperative	___ Hurts Animals	___ Quarrels	___ Unsafe Behaviors
___ Cyber Addiction	___ Imaginary Friends	___ Sad	___ Unusual Thinking
___ Defiant	___ Impulsive	___ Selfish	___ Weight Loss
___ Depression	___ Irritable	___ Separation Anxiety	___ Withdrawn
___ Destructive	___ Lazy	___ Sets Fires	___ Worries Excessively
___ Difficulty Speaking	___ Learning Problems	___ Sexual Acting Out	___ Other _____
___ Dizziness	___ Lies Frequently	___ Shares	_____
___ Drug Dependence	___ Listens to Reason	___ Short Attention Span	_____

Please describe any of the above (or other) concerns: _____

Any additional information that you believe would assist me in understanding your child/adolescent?

_____

_____

Any additional information that would assist me in understanding current concerns or problems?

What are your goals for the child's therapy? _____

_____

Do you believe the child is suicidal at this time? _____ Yes _____ No
If Yes, explain: _____

Signature of Parent/Guardian _____ Date: _____