Good Healer Christian Counseling
Jason Bien, MAMFC, MACE, LPC
www.jasonbien.com

CLIENT'S PERSONAL HISTORY FOR A MINOR

(This information is necessary for our files and is strictly confidential)

A. PARENT/GUARDIAN INFORMATION:

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Relationship to Client: _____

How long have you lived in this state? _____ In this country? _____ Do you move often/seldom? _____

Occupation: _____ Employer: _____ Length at Job: _____

Religious Preference: _____ Church Member: YES NO

If you attend church, what is the church name? _____

Marital Status: SINGLE ENGAGED MARRIED SEPARATED REMARRIED DIVORCED WIDOWED

Length of Current Marriage: _____ Number of Marriages: _____

Spouse's Name: _____ Age: _____

Spouse's Occupation: _____ Length at Job: _____

Child's Name: _____ Age: _____ Gender: MALE FEMALE

Child's Name: _____ Age: _____ Gender: MALE FEMALE

Child's Name: _____ Age: _____ Gender: MALE FEMALE

Child's Name: _____ Age: _____ Gender: MALE FEMALE

What concerns have brought you to counseling? _____

_____

Where are your concerns causing the most problems for you? *(Please circle ALL that apply)*

HOME WORK MARRIAGE RELATIONSHIP WITH OTHERS GOD

What concerns about you have others identified? _____

_____

Please rate the severity of your current concerns on the following scale:

0 1 2 3 4 5 6 7 8 9 10

MILD MODERATE SEVERE INCAPACITATING

Are you now or have you in the past seen another counselor about your concerns, please explain? _____

_____

B. CHILD/ADOLESCENT QUESTIONNAIRE:

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Client's Name: _____

School: _____ Grade: _____

Family Composition
List by name member of the child's family in order of age, beginning with the older parent first, including, mother, father, brothers, and sisters of child. Please include half-sisters and half-brothers, stepparents, stepbrothers, and stepsisters.

Member	Age	Date of Birth	Relationship	Lives in Home		Occupation and Level of Education
				YES	NO	
				YES	NO	
				YES	NO	
				YES	NO	
				YES	NO	
				YES	NO	
				YES	NO	

Parent's Marital Status: SINGLE MARRIED SEPARATED WIDOWED DIVORCED

Medical and Developmental History
This is a very important section of our study for the child. The information you provide is confidential.

1. Was the child adopted? _____ If yes: At what age? _____ Does he/she know? _____
2. Immunizations current? _____ *(please provide copy of his/her immunization records)*
3. Current health problems? _____
4. Pediatrician or family physician: _____ Date last seen: _____

Before Birth

Were any of the following conditions present during the mother's pregnancy? *(Circle all that apply)*

HIGH BLOOD PRESSURE USE OF NON-PRESCRIBED DRUGS ALCOHOL CONSUMPTION BLEEDING

SMOKING CIGARETTES NAUSEA HEADACHES ACCIDENTS SWELLING VOMITING

INFECTIONS CONVULSIONS DIABETES ANEMIA

What were the stressors during pregnancy? _____

Total weight gain: _____ Length of pregnancy: _____

List all medications taken during pregnancy: _____

Was the pregnancy planned? _____ Was the pregnancy desired? _____

At Birth

Type of anesthesia: _____ Type of delivery: NATURAL FORCEPTS CESAREAN

Did the baby have any of the following problems: *(Circle all that apply)*

RESUSCITATION REQUIRED BORN AT HOME INCUBATION BREATHING BLEEDING INFECTION

COLIC JAUNDICE OTHER: _____

Birth Weight: _____ lbs. _____oz. Length: _____in. Hospital/Location: _____

Infancy and Early Childhood

From birth to age three, who was the child's primary caretaker? _____

Were there periods the caretaker was away from the child? YES NO If yes, how long? _____

Who care for the child during this period? _____

Did the primary caretaker experience any of the following significant difficulties during the period? _____

If the caretaker worked outside the home, who cared for the child? _____

Was the child a cuddly baby? YES NO Irritable baby? YES NO

At what age did the child: Sit Alone _____ Crawl _____ Walk _____ Stay dry during the night _____

Stay dry during the day _____ Speak several words together _____ Sleep through the night _____

Not soil underwear _____ Speak in sentences _____

Childhood

Describe the child's temperament or disposition: _____

Describe the mother's temperament or disposition: _____

Describe the father's temperament or disposition: _____

Which best describes the child's development? SLOW FAST NORMAL
What is your opinion of the child's intelligence BELOW AVERAGE AVERAGE ABOVE AVERAGE

Additional Comments: _____

At what age did the child ride a: standard bicycle? _____ bicycle without training wheels? _____

Does the child wet the bed or his/her pants? If so, how often? _____

Does the child soil his/her pants? If so, how often? _____

Does the child know how to: *(Circle all that apply)* BRUSH TEETH DRESS SELF USE TOILET WITHOUT HELP

MAKE BED COMB HAIR TIE SHOES TELL TIME (NON-DIGITAL)

Sexual Development

Age at onset of menstruation? _____ Has menses been regular? _____

Has child had sex education? If yes, by whom? _____

Have there been problems in the sexual adjustment of the child? If yes, please explain. _____

_____

Has the child been sexually abused? If yes, when and by whom? _____

School History

Did the child attend preschool? If yes, at what age? _____

Child entered the first grade at what age? _____ Is the child in Special Education? If yes, since what grade? _____

Has the child ever repeated a grade(s)? If yes, what grade(s)? _____

How many schools has your child attended? _____ Is your child currently experiencing difficulty in school? If yes,

please explain: _____

Juvenile History

Does the child care about the rights of others? _____ Does the child like making others angry? _____

Does the child break rules on purpose? _____ Does the child like to do the opposite of what they are told? _____

Is the child disobedient? _____ Has the child ever had problems involving the police or juvenile authorities? If yes,

please explain and give the name of the child's probation officer: _____

_____

Family History

Has any other member of the child's family:

1. Received psychiatric or mental health treatment? If yes, who? _____
2. Received drug and/or alcohol treatment? If yes, who? _____
3. Received psychiatric medication? *(Including tranquilizers and antidepressants)* If yes, who? _____
4. Been on probation? If yes, who? _____
5. Been placed in jail? If yes, who? _____
6. Been place in prison? If yes, who? _____

Religious History

Child's religion: _____ Child attends church: REGULARLY OCCASIONALLY SELDOM NEVER

Has there been a recent change in religious beliefs? _____ Is religion important to the child? _____

How important is religion to the child's family? _____

Presenting Problems

What are the problems that caused you to seek help for the child? _____

_____

Did anything happen at the same time these problems began that may have caused these problems? If yes, please explain? _____

Was there ever a time when these problems were better? If yes, please explain? _____

_____

How long have these problem existed with the child? _____
Has the child ever seen another individual(s) or agency with regard to these problems? If yes, please give us the name of the individual/agency: _____

Have medications ever been prescribed for these problems? If yes please list the medication name and the dosage:

_____

_____

C. SYMPTOM QUESTIONNAIRE:

Listed below are items concerning children's behavior or the problems they sometimes have. Read each item carefully and decide how much your child has been bothered by this problem during the past **MONTH**. Indicate your choice by placing a check mark in the appropriate column to the right of each item. PLEASE ANSWER ALL QUESTIONS.

OBSERVATIONS	NOT AT ALL	SOMEWHAT	PRETTY MUCH	VERY MUCH
Problems with Eating				
Picky and Finicky				
Will Not Eat Enough				
Overeats				
Problems with Sleeping				
Restless				
Nightmares				
Awakens at Night				
Cannot Fall Asleep				
Fears and Worries				
Afraid of New Situations				
Afraid of People				
Afraid of Being Alone				
Worries About Illness/Death				
Muscular Tension				
Gets Stiff and Rigid				
Twitches, Jerks, Etc.				
Shakes				
Stuttering				
Difficult to Understand				
Wetting				
Wets Bed				
Runs to Bathroom				
Bowel Problems				
Soils Self				
Holds Back Bowel Movements				

OBSERVATIONS	NOT AT ALL	SOMEWHAT	PRETTY MUCH	VERY MUCH
Complains of the Following Although Doctors Cannot Find Anything Wrong				
Headaches				
Stomach Aches				
Vomiting				
Aches and Pains				
Loose Bowels				
Problems of Fidgetting				
Sucks Thumb				
Bites or Picks Nails				

Chews on Clothes, Blankets, Etc.				
Picks at Things such as Hair, Clothing, Etc.				
Childish or Immature				
Does Not Act His/Her Age				
Cries Easily				
Wants Help Doing Things He/She Should Do Alone				
Clings to Parents or Other Adults				
Baby Talks				
Trouble With Feelings				
Keeps Anger to Self				
Lets Himself/Herself Get Pushed Around By Other Children				
Unhappy				
Carries A Chip on His/Her Shoulder				
Bullying				
Bragging and Boasting				
Sassy to Adults				
Problems Making Friends				
Shy				
Afraid They Do Not Like Him/Her				
Feelings Hurt Easily				
Has No Friends				
Problems With Siblings				
Feels Cheated				
Mean				
Fights Constantly				
Problems Keeping Friends				
Disturbs Other Children				
Wants to Run Things				
Picks on Other Children				
Activity				
Restless or Overactive				
Excitable/Impulsive				
Fails to Finish Things He/She Starts				
Short Attention Span				
Difficulty Remaining Seated During Meal Times				

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OBSERVATIONS	NOT AT ALL	SOMEWHAT	PRETTY MUCH	VERY MUCH
Temper				
Temper Outbursts, Explosive and Unpredictable Behavior				
Throws Himself/Herself Around				
Throws and Breaks Things				
Pouts and Sulks				
Sexuality				
Plays with His/Her Own Sex Organs				
Involved in Sexual Play With Others				
Modest About His/Her Body				
School				
Has Difficulty Learning				
Does Not Like to go to School				
Is Afraid to go to School				
Daydreams				
Truancy				
Will Not Obey School Rules				
Lying				
Denies Having Done Wrong				
Blames Others For His/Her Mistakes				
Tells Stories Which Did Not Happen				
Stealing				
From Parents				
At School				
From Stores and Other Places				
Fire Setting				
Sets Fires				
Trouble with Police				
Gets Into Trouble with Police				
Perfectionism				
Everything Must be Just So				
Things Must be Done the Same Way Every Time				
Sets Goals Too High				
Additional Problems				
Inattentive/Easily Distracted				
Constantly Fidgeting				
Cannot be Left Alone				
Always Climbing				

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LIMITS OF CONFIDENTIALITY

Information I discussed in the therapy setting is held confidential and will not be shared without written permission except under the following conditions:

1. The client threatens suicide.
2. The client threatens harm to another person(s), including murder, assault, or other physical harm.
3. The client is a minor (under 18) and reports suspected child abuse, including but not limited to, physical beatings and sexual abuse.
4. The client reports abuse of the elderly.
5. The client reports sexual exploitation by a therapist.

State law mandates that mental health profession as may need to report these situations to the appropriate persons and/or agencies.

Communications between the clinician and the client will otherwise be deemed confidential as stated under the laws of this state.

CONSENT FOR COUNSELING MINORS

This is to certify that I give permission to Good Healer Christian Counseling for the treatment of my child.

This counseling may include individual or group psychotherapy, counseling and testing. This counseling may include consultations with other associates of this agency.

This counseling may also include referrals to other appropriate State and County or professional agencies for further counseling.