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of Southern California

CHILD PERSONAL HISTORY FORM

Please complete and return. If you would like to provide additional information, please use the back of the form. Please submit any educational, neurological, or psychological records that you feel would benefit the therapist in learning about your child.

General Information

Child's Name:	Date:	Sex:
Name of Person filling out form:	Client DOB:	Preferred Contact phone #:
Relationship to Child:	Social Security #:	Alternative Phone #(s):
Address:	Email Address:	Emergency Contact Name/Phone:
Parent 1's Name:	Parent 2's Name:	Name(s) of Siblings:

Seeking the following Services:

___ Relationship Development Intervention (RDI) ____Family Therapy

___Individual Therapy _____Behavioral Therapy ___Educational Consultation

__ Parent Training ___ Group Therapy ___ Other: Please specify

Primary reason(s) for seeking services:

___Autism Spectrum _____Social Issues ____Development Delays

___ Anger Management _____Parenting Issues ____Anxiety

___Coping _____Depression ____ Eating disorder

___Fear/phobias _____Sexual concerns ____ Sleeping problems

___Compulsive behaviors _____Alcohol/drugs ____Hyperactivity

___ Other mental health concerns (specify): _____

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Please select:

___American Indian ___Asian ___Black ___Hispanic ___Pacific Islander ___White ___Two or more races ___Other

Language(s) spoken at home: _____
Religious Preference, if applicable: _____

Please answer the following questions to the best of your ability:

1. **Goals**: What are your goals for coming here? Please be as specific as possible.

2. **Opinions a:** Is there any difference of opinion among different family members over whether problems exist, or what needs to be done? If so, please give us each person's viewpoint of the problems and solutions.

3. **Opinions b:** How about others who know your child (i.e., teachers)? Have they noted any problems or differences? What is their view about what needs to be done to address these issues? Is there any difference of opinion between you and the school? If so, please give us their viewpoints as well as yours.

4. **Living Arrangements:** With whom does the child live at this time?

5. **Child Expectations**: Does the child know why they are coming? If so, what do they know and expect?

6. **Marriage**: Please tell us about parents' marital status. Is this the first marriage for both? If there were prior marriages, are there any children from them? Are parents divorced? Remarried? Separated? If divorced, tell us your opinion of the impact of the divorce on the child. Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling?

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7. Parent 1:

____ Natural parent ____ Step-parent ____Adoptive parent ___Foster home ____ Other (specify):

Please tell us about your occupation.

Are you currently working? _____ Part time/Full time? _____

Where employed: _____Work phone: _____

Parent 1's education: _____

Is there anything notable, unusual or stressful about the child's relationship with the parent 1?

____ Yes __ No If Yes, please explain: _____

_____

How is the child disciplined by parent 1? _____

For what reasons is the child disciplined by parent 1? _____

8. Parent 2:

____ Natural parent ____ Step-parent ____Adoptive parent ___Foster home ____ Other (specify):

Please tell us about your occupation.

Are you currently working? _____ Part time/Full time? _____

Where employed: _____Work phone: _____

Parent 2's education: _____

Is there anything notable, unusual or stressful about the child's relationship with the parent 2?

____ Yes __ No If Yes, please explain: _____

_____

How is the child disciplined by parent 2? _____

For what reasons is the child disciplined by parent 2? _____

9. Adoption: If your child was adopted, at what age was the adoption? What information do you have about the history of the biological parents and the child's history before the adoption?

10. Brothers and sisters: Tell us any important information about siblings that would help us. Please include quality of the relationship with client.

11. Caregivers: Please tell us about the adults involved with this child on a regular basis.

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12. Family Health:

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

___ Allergies	_____Muscular Dystrophy	_____Deafness
___ Anemia	_____Diabetes	_____Nervousness
___ Perceptual motor disorder	_____Glandular problems	_____Asthma
___ Blindness	_____High blood pressure	_____Seizures
___ Cancer	_____Kidney disease	_____Spinal Bifida
___ Cerebral Palsy	_____Mental illness	_____Suicide
___ Cleft lips	_____Migraines	_____Other (specify):
___ Cleft palate	_____Multiple sclerosis	_____

Comments re: Family Health: _____

_____

13. Stress: Please tell us about any recent stresses and crises that have occurred in the family in the last few years. For any stress you list, tell us how you think it may have affected your child. (Include a parent who must work unusually long hours in the list of stresses. Also, include any anticipated future stresses.)

14. Pregnancy: Please tell us about the pregnancy and delivery of this child. Were there any stresses or problems?

15. Early: Please tell us anything significant about this child's first months of life. What, if anything did you notice was significant in the first year? What about his or her development was different from what you expected?

16. First 18 months: Please share anything you feel is especially notable about the child's early development during the first 18 months. What about his or her development was different from what you expected?

17. Medical History: Please share anything notable about the child's medical status, including neurological problems and allergies.

___ Abortion	____Hay fever	_____Pneumonia
___ Asthma	____Heart trouble	_____Polio

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____ Blackouts	____Hepatitis	____Pregnancy
___ Bronchitis	____Hearing	____Speech
___Hives	____Rheumatic Fever	____Sensory/Motor
____ Cerebral Palsy	____Influenza	____Scarlet Fever
___ Chicken Pox	____Lead poisoning	____Seizures
____ Congenital problems	____Measles	____Severe colds
___ Croup	____Meningitis	____Meningitis
___ Diabetes	____Miscarriage	____Headaches
___Sexually transmitted disease	____Multiple sclerosis	____Thyroid disorders
____ Dizziness	____Mumps	____Vision problems
____ Ear aches	____Muscular Dystrophy	____Wearing glasses
____ Ear infections	____Nose bleeds	____Whooping cough
____ Eczema	____Other skin rashes	____Other
___ Encephalitis	____Paralysis	_____

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

Current prescribed medications effects	Dose	Dates	Purpose	Side

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

18. Education:

Current school: _____ School phone number: _____
Type of school: ____ Public ____ Private ___ Home schooled _____ Other (specify): _____
Grade: _____ Teacher: _____ School Counselor: _____
In special education? ____ Yes ____ No If Yes, describe: _____
In gifted program? ____ Yes ____ No If Yes, describe: _____
Has child ever been held back in school? _____ Yes ____ No
If Yes, describe: _____
Which subjects does the child enjoy in school? _____

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Which subjects does the child dislike in school? _____
What grades does the child usually receive in school? _____
Have there been any recent changes in the child's grades? _____Yes _____No
If Yes, describe: _____
Has the child been tested psychologically? _____Yes _____NO
If Yes, describe: _____

Check the descriptions which specifically relate to your child.

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: ____Parent 1 ____ Parent 2 ___ Shared ____ Other (specify): _____
Health: ____Parent 1 ____ Parent 2 ___ Shared ____ Other (specify): _____
Problem behavior: ____Parent 1 ____ Parent 2 ___ Shared ____ Other (specify): _____

If the child is involved in a vocational program or works a job, please fill in the following:
What is the child's attitude toward work? ____ Poor ___ Average ____ Good ____ Excellent
Current employer: _____ Position: _____ Hours per week: _____
How have the child's grades in school been affected since working? _____ Lower ____ Same ____ Higher
How Many previous jobs or placements has the child had? _____
Usual length of employment: _____ Usual reason for leaving: _____

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19. **Counseling/Prior Treatment History:** Please share with us any prior about any prior counseling the child has received. What worked? What did not work?

20. **Behavioral/Emotional:**

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

___ Affectionate
___Sad
___ Aggressive
___Selfish
___ Difficulty attaching to caregivers
___Limited emotional expression
___Can't stop him or herself from taking actions when specifically warned of consequences
____Alcohol problems
___ Angry
___ Anxiety
___Sexual addiction/Sexual acting out
___ Difficulty shifting attention
___Doesn't understand or show anxiety for hazards such as fire, cliff
___Hopelessness
___Short attention span
___Sick often
___ Blinking, jerking
____Impulsive
___ Bullies, threatens
___Sleeping problems
___Lazy
___Learning problems
___ Clumsy
___Speech problems
___Loner
___Low self-esteem
___ Defiant
___Suicidal attempts
___Moody
___ Destructive
___Teeth grinding
___Obedient
___ Dizziness

____Frustrated easily/poor frustration tolerance
____Rage
____Gambling
____Sets fires
____ Difficulty understanding consequences
____Approaches strangers
__Separation anxiety
____Hallucinations
____Head banging
____ Avoids adults
___over-focused
____Hurts animals
____ Bedwetting
____ Bizarre behavior
____Imaginary friends
____Shy, timid
____Irritable
____ Careless, reckless
____Slow moving
____Soiling
____Lies frequently
____Steals
____ Cyber addiction
____Suicidal threats
____Messy
____ Depression
____Talks back
____Nightmares
____ Difficulty speaking
____Thumb sucking
____Often sick

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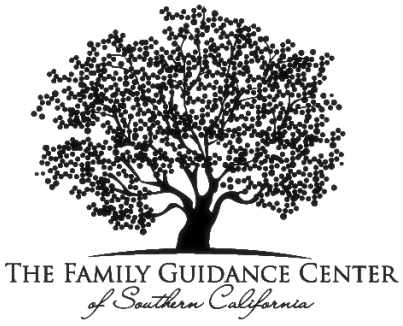
____Toilet issues
___ Drugs dependence
___Unsafe behaviors
____ Picky Eating
___Over active
___ Enthusiastic
___Weight loss
___Panic attacks
___ Expects failure
___Worries excessively
___Poor appetite
___ Fearful
___ Frequent injuries

_____Tics or twitching
_____Oppositional
_____ Eating disorder
____Food aversions
_____Unusual thinking
_____Over weight
_____ Excessive Masturbation
_____Withdrawn
_____Phobias
_____ Fatigue
_____Other:
_____Psychiatric problems
_____Quarrels with others

21. Leisure/Strengths:

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.) What are the family's favorite activities? What does the child/adolescent do with unstructured time? What would you consider your child's strengths to be?

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