The Gentle Shepherd Counseling Center

CHILD AND ADOLESCENT HISTORY FORM

Identifying Information Date _____

Person completing the form _____

Relationship to Child _____

Child's Name _____Birthdate_____Age____

Address _____

Phone Number _____

Current School _____Grade _____

Child's Physician _____Date of last Dr.'s visit: _____

FAMILY HISTORY:

MOTHER	FATHER
Name	Name
Birthdate	Birthdate
Address	Address
Phone H) W)	Phone H) W)
Occupation	Occupation
Highest Level of Education	Highest Level of Education

OTHER IMMEDIATE FAMILY			
Name	Age	Relationship to Child	Occupation/Grade

Reasons for seeking mental health services for this child: _____

_____

_____

How long has this been a problem for this child? _____

Has this child had any previous counseling or psychological assessment?_____

_____

If so, when and with whom?_____

Has this child experienced any of the following?	Yes	No	Date
Parents separated			
Parents divorced			
Father / mother in new significant relationship			
Father / mother arrested			
Physical violence between child's parents			
Child separated from parents			
Child changed schools			
Child or family moved			
Child physically or sexually abused			
Brother / sister physically or sexually abused			
Child arrested / placed in Juvenile Hall			
Birth of brother or sister			
Brother / sister left home or separated from family			
Family had serious financial problems			
Major illness / accident			
Child			
Father / Mother			
Brother / Sister			
Death of			
Father / Mother			
Brother / Sister			
Other Relative			
Friend			

Please briefly outline the history of your child's family relationships. Include any non-family members who have provided primary or day care for extended periods.

_____

_____

_____

_____

_____

_____

_____

Are there any current court orders regarding custody or guardianship of this child? _____

Please outline: _____

_____

_____

How has this child handled separations from family?

_____

_____

DEVELOPMENTAL HISTORY:

Pregnancy:

Mother's age during pregnancy _____Father's age: _____
Was this pregnancy planned? Yes _____ No _____
Briefly describe any problems, if any, during the pregnancy: _____
_____
Were drugs, alcohol or tobacco used during the pregnancy? _____

Birth:

Please describe any complications with the labor or delivery: _____
_____

Newborn:

Was this child premature or overdue? Yes _____ No _____
Birth weight: _____
Were there any difficulties or peculiarities in this child's appearance or behavior at birth of during infancy? _____
If yes, please describe: _____
_____

Early Growth and Development:

Were there any problems in feeding this child as an infant? _____
Was this child bottle or breast-fed? _____How long? _____
How would you describe this child as a baby? (friendly, shy, etc.) _____
_____
At what age was toilet training begun? _____How was it initiated?
_____
_____
Were there any difficulties? _____
_____

Compared with other children, was this child's development fast, slow, normal? ___
_____
Does this child seem easier, the same or harder to raise than your other children or like age children you know? _____
Is your child right or left handed? _____Age this was clear? _____
Well coordinated? _____ Clumsy? _____ Good with hands? _____
Daredevil behavior? _____ Impulsiveness? _____
Unusual fears? _____ Sleep problems? _____
Rocking? _____ Head bumping? _____
Describe your child's sleep patterns and habits? _____
_____
Describe your child's eating patterns and habits? _____
_____
Have you had any concerns about your child's sexual development or awareness?
_____
_____

Has this child had any difficulty with elimination patterns (e.g. soiling, bed wetting, constipation, etc.)

Describe your child's personal strengths and skills:

What is your child's general approach to handling:

Frustration:

Competition:

Conflict:

Stress:

In general, how does your child relate to others: adults, teachers, friends:

SCHOOL HISTORY:

How many schools has your child attended?
Current grade in school Current teacher
Has your child's teacher reported any problems in school?
Please describe:

Please describe your child's school behavior and performance.

Does your child receive specialized services in school (for example, speech therapy, resource classroom, special education class)?

Has your child repeated a grade, if so, which grade?
Are you satisfied with your child's performance at school?
If no, please explain:

Briefly describe your child's educational or childcare experiences thus far, including a general indication of your child's adjustment to school and any difficulties experienced:

Briefly describe your child's physical development and current level of involvement in sports or exercise: _____

_____

_____

MEDICAL HISTORY:

Please indicate if the child has experienced any of the following:

	Yes	No		Yes	No
Chicken Pox			Measles		
Severe headaches			Asthma		
Head injury			Shortness of breath		
Fainting spells			Frequent diarrhea/constipation		
Periods of unconsciousness			Frequent nausea or vomiting		
Seizures or convulsions			Episodes of prolonged high fever (103)		
Vision problems			Bedwetting		
Frequent ear trouble			Soiling		
Hearing impairment			Speech problems		
Heart disease			Operations		
Abrupt weight loss/gain			Encephalitis		
Meningitis			Whooping cough		
Mumps			Other illness/injury		
Hospitalizations					

Does your child have any known allergies? _____ Please outline:_____

_____

_____

Have there been any other significant health concerns or injuries? Please describe: _____

_____

_____

List any medications the child is currently taking: _____

_____

_____

FAMILY HEALTH HISTORY:

Please indicate if the child or any blood relative has had an illness listed below. Include the child, mother, father, sister, brother, grandparents, aunts and/or uncles.

Learning disabilities	
Allergies (medicines, foods, pollen)	
Alcoholism or drug addiction	
Blood disease (hemophilia, anemia)	
Bone or joint disorders (arthritis)	
Cancer	
Chronic lung disease (asthma, bronchitis)	
Blindness or deafness	
Glandular disease (diabetes, thyroid)	
Heart disease	
Kidney or urinary disease	
Nerve disease (cerebral palsy, epilepsy)	
Depression	
Other mental or emotional problem	