

The Gentle Shepherd Counseling Center

CHILD AND ADOLESCENT HISTORY FORM 2022

IDENTIFYING INFORMATION

Date _____

Person completing this form _____

Relationship to Child _____

Child's Full Name _____ Birthdate _____ Age _____

Address _____

Phone Number _____ Email Address _____

Current School _____ Grade _____

Child's Primary Physician _____

Date of Last Physician's Visit _____

FAMILY HISTORY

MOTHER	FATHER
Name	Name
Birthdate	Birthdate
Address	Address
Phone	Phone
Email Address	Email Address
Occupation	Occupation
Highest Level of Education	Highest Level of Education

OTHER IMMEDIATE FAMILY MEMBERS			
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 treatment/assessments? ____ Yes
 ____ No If yes, when and with whom? _____

Has this child experienced any of the following?	Yes	No	Age/Date
Parents separated			
Parents divorced			
Father/Mother in new significant relationship			
Father/Mother arrested or incarcerated			
Physical violence between child's parents			
Child separated from parents/removal from home			
Child changed schools			
Child or family moved			
Child physically abused			
Child sexually abused			
Brother/sister physically abused			
Brother/sister sexually abused			
Child arrested or placed in juvenile detention center			
Birth of brother or sister			
Inadequate housing			
Poverty			
Food insecurity			
Major Illness/accident of:			
Child			
Father/Mother			
Brother/Sister			
Friend			
Death of:			
Father/Mother			
Brother/Sister			
Grandparent			
Friend			
Pet			

Briefly describe this child's family relationships: _____

Are there any court orders regarding custody or guardianship of this child? ____ Yes ____ No
 If yes, please describe: _____
 (Any court-ordered custody, medical or guardianship agreements must be provided.)

DEVELOPMENTAL HISTORY

Pregnancy

Mother's age during pregnancy _____ Father's age _____

Was the pregnancy planned? () Yes () No

Briefly describe any problems, if any, during pregnancy (e.g. high blood pressure, bed rest, etc.): _____

Were drugs, alcohol or tobacco used during pregnancy? () Yes () No If yes, what was used? _____

Birth

Describe any complications, if any, with labor and/or delivery of this child: _____

Was this child premature or overdue? _____ C-Section birth? () Yes () No

Birth Weight _____

Early Growth and Development

Delayed Developmental Milestones (check only those that were not reached at expected age)

() rolling over () sitting () crawling/walking () tolerating separation () speaking

() toilet training () growth delay/failure to thrive

Social, Emotional and Behavioral Considerations

Describe this child's sleep patterns and habits: _____

Describe this child's eating patterns and habits: _____

Have you had concerns about this child's sexual development or awareness? () Yes () No

If yes, please describe: _____

Has this child had any difficulties with elimination patterns (soiling, wetting the bed, constipation, etc)? () Yes () No

If yes, please describe: _____

Describe this child's personal strengths and skills: _____

In general, how does this child relate to others (adults, teachers, friends, etc.)? _____

Have you had any of the following concerns with this child's behavior? () anxiety () stealing

() drug use () bullying others () frequent sadness () impulsivity () alcohol use

() indecisiveness () disobedience () hostility/anger () hyperactivity () extreme worrying

() self-injury () fire-setting () easily distracted () avoidance of people/situations

() trouble concentrating () feeling hopeless () fixed/rigid interests

() difficulty making friends or reading social cues () suicidal tendencies

SCHOOL HISTORY

How many schools has this child attended? _____

Current grade in school: _____ Current school: _____

Has your child’s teacher reported any problems at school? () Yes () No

If yes, please describe: _____

This child has experienced the following at school: () normal school interaction/performance () authority problems () academic concerns () discord with teachers/peers () poor motivation and/or procrastination () bullying from peers

Does this child receive any specialized services or accommodations in school? () Yes () No

If yes, please describe: _____

Does this child have an Individualized Education Plan (IEP) or 504 Plan? () Yes () No

If yes, please identify and explain: _____

Has this child repeated a grade? () Yes () No If yes, what grade? _____

Briefly describe this child’s current involvement in school sports and activities:

Briefly describe this child’s involvement in spiritual/religious activities: _____

MEDICAL HISTORY

Please indicate below if this child has had any of the following illnesses or conditions.

	Yes	No		Yes	No
Autoimmune disease			Addictions (specify)		
Migraines/severe headaches			Asthma		
Head injury			Shortness of breath		
Fainting spells			Frequent diarrhea/constipation		
Seizures or convulsions			Episodes of high fever (103+)		
Vision problems			Bedwetting		
Frequent ear infections			Frequent nausea or vomiting		
Hearing impairment			Speech problems		
Heart disease or other heart condition			Other Viral Infections (Specify)		
Abrupt weight loss/gain			Encephalitis		
Meningitis			Eating Disorder		
Mononucleosis			Other illness (specify)		

Does this child have any known allergies? () Yes () No If yes, please describe:

Have there been any other significant health concerns, hospitalizations, surgeries or injuries with this child? () Yes () No

If yes, please explain: _____

Please list all medications, supplements, and vitamins (including amounts, how often taken, etc.) taken by this child: _____

FAMILY HEALTH HISTORY:

Please indicate if this child or any biological relative (mother, father, sibling, grandparent, aunt, or uncle) has had an illness or condition listed below.

Please Check and Specify Illness/Condition	Please Specify if Child, Mother, Father or Other Family Member
Alcoholism or drug addiction	
Anxiety	
Blood disease (hemophilia, anemia)	
Bone or joint disorders (arthritis)	
Cancer	
Chronic lung disease (asthma, bronchitis)	
Blindness or deafness	
Endocrine disease (diabetes, thyroid)	
Autoimmune disease (MS, lupus)	
ADD/ADHD	
Heart disease or other heart condition	
Kidney or urinary disease	
Learning disabilities	
Nerve disease (cerebral palsy, epilepsy)	
Depression	
Other illness or physical health condition	
Other psychological or emotional condition (bipolar disorder, OCD, schizophrenia)	