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## Developmental & Personal History

Client's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____Grade: _____

Form completed by (if someone other than client): _____

Please indicate if client is adopted: _____Yes _____ No

**If you need any more space for any of the following questions please use the back of the sheet.**

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

**Parents**

With whom does the child live at this time? _____

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 to know in counseling? _____ Yes _____ No

If Yes, describe: _____

**Client's Mother**

Name: _____ Age: _____ Home Phone: _____

Occupation: _____ _____ FT _____ PT

Where employed: _____ Work phone: _____

**Client's Father/Other Guardian**

Name: _____ Age: _____ Home Phone:

Occupation: _____ _____ FT ____ PT

Where employed: _____ Work phone: _____

**Client'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 _____ ___ poor ___ average ___ good
_____ ___ ___ F ___ M _____ ___ poor ___ average ___ good
_____ ___ ___ F ___ M _____ ___ poor ___ average ___ good
_____ ___ ___ F ___ M _____ ___ poor ___ average ___ good

Comments: _____

_____

**Family Health History**

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

| | | |
|---|---|---|
| ___ Allergies | ___ Deafness | ___ Muscular Dystrophy |
| ___ Anemia | ___ Diabetes | ___ Nervousness |
| ___ Asthma | ___ Glandular problems | ___ Perceptual motor disorder |
| ___ Bleeding tendency | ___ Heart diseases | ___ Mental Retardation |
| ___ 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: _____

_____

**Childhood/Adolescent History**

**Pregnancy/Birth**

Length of pregnancy: _____

Mother's age at child's birth: _____ Father's age at child's birth: _____

Child number ___ of _____ total children.

While pregnant did the mother smoke? ___ Yes ___ No

Did the mother use drugs of alcohol? ___ Yes ___ No

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication) ___ Yes ___ No If Yes, describe _____

Length of labor: _____ Induced: ___ Yes ___ No Caesarean? ___ Yes ___ No

Baby's birth weight: _____ Baby's birth length: _____

Describe any physical or emotional complications with the delivery: _____

_____

Describe any complications for the mother or the baby after the birth: _____

_____

**Infancy/Toddlerhood** Check all which apply:

___ Breast fed ___ Milk allergies ___ Vomiting ___ Diarrhea

___ Bottle fed ____ Rashes ___ Colic ____ Constipation
___ Not cuddly ____ Cried often ___ Rarely cried ____ Overactive
___ Resisted solid food ____ Trouble sleeping ___ Irritable when awakened ____ Lethargic

**Developmental History** Please note the age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____
Took 1st steps: _____ Tied shoelaces: _____
Spoke words: _____ Rode two-wheeled bike: _____
Spoke sentences: _____ Toilet trained: _____
Weaned: _____ Dry during day: _____
Fed self: _____ Dry during night: _____

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

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

_____

Any speech, hearing or language difficulties?

_____

Any sensory concerns? (Please explain)

_____

**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? _____

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): _____

**Leisure/Recreational/Work**

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, vocational/work program, etc.) _____

_____

_____

**Medical/Physical Health**

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

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

**Nutrition**

Any Concerns? _____

Describe typical eating habits: _____

List any recent changes in eating: _____

**Sleep**

What time does the child/adolescent go to bed? _____

How many hours of sleep does child/adolescent typically get per night? _____

List any recent sleep changes or concerns? _____

**Most Recent Examinations**

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

| Current prescribed medications | Dose | Dates | Purpose | Side effects |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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

**Chemical Use History**

Does the child/adolescent use or have a problem with alcohol or drugs? _____ Yes _____ No

If Yes, describe: _____

**Counseling/Prior Treatment History**

Information about child/adolescent (past and present):

| | Yes | No | When | Where | Reaction or overall experience |
|---|---|---|---|---|---|
| Counseling/Psychiatric treatment | | | | | |
| Suicidal thoughts/attempts | | | | | |
| Drug/alcohol treatment | | | | | |
| Hospitalizations | | | | | |

Residential placements, institutional placements, or foster care?

Dates of placement _____

Program name or location _____

Reason for placement _____

**Behavioral/Emotional**

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

___ Affectionate
___ Aggressive
___ Alcohol problems
___ Angry
___ Anxiety
___ Attachment to dolls
___ Avoids adults
___ Bedwetting
___ Blinking, jerking
___ Bizarre behavior
___ Bullies, threatens
___ Careless, reckless
___ Chest pains
___ Clumsy
___ Confident
___ Cooperative
___ Cyber addiction
___ Defiant
___ Depression
___ Destructive
___ Difficulty speaking
___ Dizziness
___ Drugs dependence
___ Eating disorder
___ Enthusiastic
___ Excessive masturbation
___ Expects failure
___ Fatigue
___ Fearful
___ Frequent injuries
___ Frustrated easily
___ Gambling
___ Generous
___ Hallucinations
___ Head banging
___ Heart problems
___ Hopelessness
___ Hurts animals
___ Imaginary friends
___ Impulsive
___ Irritable
___ Lazy
___ Learning problems
___ Lies frequently
___ Listens to reason
___ Loner
___ Low self-esteem
___ Messy
___ Moody
___ Nightmares
___ Obedient
___ Often sick
___ Oppositional
___ Over active
___ Overweight
___ Panic attacks
___ Phobias
___ Poor appetite
___ Psychiatric problems
___ Quarrels
___ Sad
___ Selfish
___ Separation anxiety
___ Sets fires
___ Sexual addiction
___ Sexual acting out
___ Shares
___ Sick often
___ Short attention span
___ Shy, timid
___ Sleeping problems
___ Slow moving
___ Soiling
___ Speech problems
___ Steals
___ Stomach aches
___ Suicidal threats
___ Suicidal attempts
___ Talks back
___ Teeth grinding
___ Thumb sucking
___ Tics or twitching
___ Unsafe behaviors
___ Unusual thinking
___ Weight loss
___ Withdrawn
___ Worries excessively
___ Other: _____
_____

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

_____

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.)

___ Yes ___ No If Yes, describe: _____

_____

Is there anything else I should know that doesn't appear on this/other forms that is or might be important?

_____

_____

_____

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

_____

_____

_____

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

_____

What family involvement would you like to see in the therapy? _____

_____

Do you believe the child is suicidal at this time? _____ Yes _____ No

If Yes, explain: _____

_____

**********

**For Staff Use**

Therapist's comments: _____

_____

_____

_____

_____

Therapist's signature: _____ Date: ____/____/_____

Other recommendations: _____

_____

_____ Physical exam: _____ Required ___ Not required