Case Number:_____

ACS
CHILD & ADOLESCENT HISTORY

Client Name:_____Date:_____Birth Date:_____

Person Completing Form:_____Relationship to child:_____

Who is the custodial parent?_____

What are the problems your child is having?_____

_____

Are parents/guardians willing to participate in treatment?_____

What are your goals / expectations for your child's counseling?_____

_____

FAMILY

	Name	Age	School/Employer	Marital Status
Mother				
Father				
Step-Parent(s)				
Brothers/Sisters				

Others living in the home:_____

Case Number:_____

BIRTH & DEVELOPMENT

Pregnancy: Normal?_____Early Development: Normal?_____

If complications, please explain (if premature include weeks and weight):_____

_____

_____

Any prenatal exposure to alcohol, tobacco, or drugs?_____

_____

Infancy & Development: Any problem areas?

____Colic	____Underactive	____Chronic Illness	____Malnutrition
____Eating	____Infections	____High Fevers	
____Sleeping	____Slow Growth	____Hospitalizations	
____Mild or food allergies	____Fussy	____Surgeries	
	____Constipation	____Overactive	

PHYSICAL HEALTH

Last date seen by physician and reason for seeing:_____

Medical Conditions (past & present, include surgeries, hospitalizations, and treatment procedures):_____

_____

Any history of head injuries, concussions, or traumatic brain injuries?

_____

Current medications & dosages (include over the counter medications and supplements):

_____

_____

Family history of illness (including mental health and substance abuse):_____

_____

Is your child allergic to or have had a bad reaction to any medications? ☐Yes ☐No If yes, please list:_____

Case Number:_____

Are immunizations up to date? ☐Yes ☐No_____

Has your child had vision and hearing exams? Results: _____

Has your daughter begun menstruation? ☐Yes ☐No Age of onset:_____

Do you know your child to be sexually active ☐Yes ☐No _____

*In the event of pregnancy during treatment, it is important to inform the doctor if taking any medication.

RELIGIOUS AND SPIRITUAL

Mother's Background_____Father's Background_____

Does the family practice religion or spirituality? Please describe:_____

Does your child participate?_____

CULTURAL/ETHNIC BACKGROUND

What is the ethnic group(s) of child's parents?_____

Does your child identify with this same group, or another?_____

LEISURE/RECREATIONAL

Hobbies, leisure time activities, interests:_____

_____

Has his / her of activity level changed? ☐Yes ☐No If yes, explain how:_____

_____

LEGAL

Has your child ever been involved with the police or courts? Explain:_____

_____

Has your child been part of a divorce or custody issue?_____

Is your child adopted? _____When were they told?_____

Case Number:_____

FAMILY INCOME

Does your child work? ☐Yes ☐No Hours: _____Position:_____

Does the family have financial difficulties? ☐Yes ☐No

SCHOOL

School District:_____School:_____

Present Grade:_____Repeated a grade?_____Present grades?_____

How does your child feel about school?_____

Has your child ever had difficulties with: ☐Math ☐ Reading ☐Language ☐Speech ☐Hearing

_____

Has your child ever received special education services? ☐Yes ☐No

Does your child have a current IEP or 504 Plan? ☐Yes ☐No

Have you received complaints or compliments from your child's school about behavior or achievement?
Please explain:_____

Has your child ever been afraid to go to school?_____

Has your child ever been the victim of bullying?_____

BEHAVIOR

Please check any of the following that are typical of your child's behavior:

____Does not feel liked
____Feels lonely
____Shy with children
____Prefers to be alone
____Worries
____Moody
____Sad
____Cries easily
____Expects failure
____Does not share
____Lacks motivation
____Sexual acting out
____Preoccupied with sexual thoughts
____Does not feel like self
____Easy to anger
____Stubborn
____Defiant
Aggressive with:
Peers____
Siblings_____
Adults____
____Needs the last word
____Stealing from home
____Will not admit blame
____Sets fires
____Poorly organized
____Clumsy
____Poor hygiene
____Sleep difficulties
____Sleep walking
____Bedwetting – present
____Bedwetting – past
____Soiling
____Unusual thinking
____Unusual behaviors
____Violent behavior
____Destruction of property
____Not always truthful
____Fails to understand consequences
____Feelings of guilt

____Tics or twitches
____Compulsive behavior
____Talks impulsively
____Takes unnecessary risks
____Short attention span
____Daydreams
____Jealousness
____Acts impulsively
____Overactive
____Perfectionist

Has your child ever used alcohol, tobacco, or drugs? Please specify type, amount, and frequency:_____

PERSONAL ADJUSTMENT

How does your child relate to: Mother?_____Father?_____

Step parent(s)?_____Siblings?_____

Authority Figures?_____Peers?_____

COUNSELING/PRIOR TREATMENT HISTORY

How does your child feel about counseling?_____

Has your child had psychotherapy/counseling or attended a support group before? ☐Yes ☐No If yes, please list below:

Name of Center	Type of Service Outpatient/inpatient/Day Treatment	Dates	Drug or Alcohol Treatment (Y/N)

Has your child ever experienced thoughts of harming him/herself or another person? ☐Yes ☐No If yes, please explain:_____

Does your child have a history of suicide attempts or harming others? ☐Yes ☐No

If yes, please describe:_____

Has your child ever experienced or witnessed trauma, physical or sexual abuse?_____

_____

Case Number:_____

Is there anything else you would like us know about your child?_____

_____

Parent or Guardian Signature:_____

Date

-For Office Use-

_____

Therapist's Signature Date

Based on the information provided above, a physical exam □Is Required □Is Not Required

M.D./D.O. Comments_____

_____

_____

Physician Signature Date

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