

CHARLES D. MILLS, Ph.D.

CHILD/ADOLESCENT HISTORY FORM

Child's name _____ Date of Birth: _____

Form complete by: _____ Date: _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ may leave message (please circle) Yes/No

Cell Phone _____ mlm Yes/No Work Phone _____ mlm Yes/No

Emergency contact _____ Relationship to client _____ Telephone _____

Referral Source: _____

Reason for seeking counseling today: _____

Please describe what you would like to see accomplished: _____

FAMILY INFORMATION

Father's Name _____ Occupation _____

Where Employed _____ Work Phone _____

Natural Father Step Father Adoptive Father Foster Home Father's Age _____

Father's Education _____ Marital Status _____

Mother's Name _____ Occupation _____

Where Employed _____ Work Phone _____

Natural Mother Step Mother Adoptive Mother Foster Home Mother's Age _____

Mother's Education _____ Marital Status _____

If divorced, at what age was child when divorce occurred? _____

Who is the legal guardian? _____ (We must have copy of guardianship papers)

Siblings:	<u>Names</u>	<u>Age</u>	<u>Sex</u>	<u>Grade</u>	<u>(at home or away)</u>
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Others in Household:					Relationship
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Family Income Range: under 10,000 10,000-20,000 21,000-30,000 31,000-50,000 51,000 or over

FAMILY HEALTH HISTORY

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles, cousins or grandparents) Please identify:

- | | |
|-------------------------|---------------------------------|
| Allergies _____ | High Blood Pressure _____ |
| Anemia _____ | Kidney Disease _____ |
| Asthma _____ | Mental Illness _____ |
| Bleeding Tendency _____ | Migraines _____ |
| Blindness _____ | Multiple Sclerosis _____ |
| Cancer _____ | Muscular Dystrophy _____ |
| Cerebral Palsy _____ | Nervousness _____ |
| Cleft Lips _____ | Perceptual Motor Disorder _____ |
| Cleft Palate _____ | Retardation _____ |
| Deafness _____ | Seizures _____ |
| Diabetes _____ | Spinal Bifida _____ |
| Glandular _____ | Suicide _____ |
| Heart Disease _____ | Other _____ |

CULTURAL/ETHNIC BACKGROUND

What cultural or ethnic group does your family come from?

Does your family closely identify with this group, and if so, do you see this as a strength or weakness?

SPIRITUAL/RELIGIOUS INFORMATION

Does the family have a religion? Yes No

If yes, what religion? _____ Does the child practice? Yes No

Are spiritual/religious values emphasized in your home? Yes No

Why or why not? _____

Does your family attend church regularly? Yes No

Was the family or child ever a member of a formal religion? Yes No

If yes, please explain:

LEGAL

Was your child adopted? Yes No If yes, at what age? _____ Does your child know? Yes No

Has the child/adolescent ever been involved with the police or juvenile court system? Yes No

If yes, please explain:

Are the parents involved in a divorce or custody issue currently? If yes, please explain:

SUBSTANCE ABUSE HISTORY

Has the child/adolescent in the past or present used tobacco products, alcohol, illicit prescription or over-the-counter drugs? Yes No

If yes, please explain:

CHILD’S HISTORY

Pregnancy/birth:

Has the child’s mother had any occurrences of miscarriages or still born births? Yes No

If so, please explain: (when, how many)

Was the pregnancy with this child planned? Yes No What was the length of pregnancy? _____

How many pounds did mother gain during pregnancy? _____

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

While pregnant, did mother smoke? Yes No If yes, amount _____

Did mother use alcohol and/or drugs? Yes No If yes, type/amount _____

While pregnant, did mother have any medical/emotional difficulties? (hypertension, surgery, medication, depression, etc):

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 mother or baby after birth:

Length of hospitalization: Mother _____ Baby _____

Infancy/Toddlerhood:

Check all that apply:

- | | | | |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Breast Fed | <input type="checkbox"/> Milk Allergies | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bottle Fed | <input type="checkbox"/> Rashes | <input type="checkbox"/> Colic | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Not cuddly | <input type="checkbox"/> Cried a lot | <input type="checkbox"/> Rarely cried | <input type="checkbox"/> Overactive |
| <input type="checkbox"/> Resisted solid food | <input type="checkbox"/> Difficult to feed | <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Lethargic |

Developmental history:

Has child ever been separated from parent? Yes No

Age at which:

Sat alone _____

Weaned _____

Rode 2-wheel bike _____

Took first steps _____

Fed self _____

Toilet trained _____

Spoke words _____

Dressed self _____

Dry during day _____

Spoke sentences _____

Tied shoe laces _____

Dry during night _____

Compared with others in the family, child's development was: Slow Average Fast

Age for following developments: (to be completed where applicable)

Began Puberty _____ Breast development _____ Convulsions _____
Voice change _____ Menstruation _____ Injuries or hospitalization _____

Is child's nutrition adequate? Yes No If no, please explain _____

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

Allergies/adverse reactions to treatment: _____

Primary Care Physician: _____

Address: _____ City _____ State _____ Zip _____

MEDICAL

Has your child had:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Mumps | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Severe Colds |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Fevers | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Severe Head Injury |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Other skin rashes | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Croup | <input type="checkbox"/> Hives | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Wear Glasses |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other medical history problem(s): _____ | | |

Date of child's last physical examination: _____

Results: _____

Hearing Exam: _____ Results: _____

Eye exam: _____ Results: _____

Child's last visit to the dentist: _____

Is your child currently taking any medication? Yes No

If so, name of medication, dosage, and reason:

At present, how is your child's health? Good Fair Poor

Immunization Record:

	DPT	POLIO	
2 months	_____	_____	15 months _____ MMR (Measles, Mumps, Rubella)
4 months	_____	_____	24 months _____ HBPV (Hib)
6 months	_____	_____	
1 ½ years	_____	_____	
4-5 years	_____	_____	

EDUCATION

Current school _____ School Phone # _____

Grade _____ Teacher _____ School Counselor _____

Describe the following:

Placement in special education/gifted program:

Retention or acceleration in grade placement:

Which subjects are easy for your child?

What grades does your child receive?

Has your child been psychologically tested? Yes No

Check the phrases which specifically relate to your child:

Feelings about school work:

- Anxious Passive Enthusiastic Fearful
- Eager No Expression Bored Rebellious

Approach to school work:

- Organized Industrious Responsible
- Interested Self Directed Does only what is expected
- No Initiative Refuses Does not complete assignments
- Sloppy Disorganized Cooperative

Performance In School – Parent’s Opinion:

Satisfactory

Underachiever

Overachiever

Child’s Peer Relationships:

Spontaneous

Follower

Leader

Shares easily

Makes friends easily

Long-time friends

Difficulty making friends

Poor choices of friends

Positive choices of friends

Who handles responsibility for your child in the following areas?

School:

Mother

Father

Shared

Other

Health:

Mother

Father

Shared

Other

Problem Behavior:

Mother

Father

Shared

Other

SOCIAL

Personal Adjustment:

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

Shy, timid

Temper tantrums

Unusual thinking

Worries

Lies frequently

Bizarre behavior

Moody

Destructive

Blinking, jerking

Sad, cries

Steals

Speech problems

Loner

Sets fire

Learning problems

Expects failure

Stomach aches

Cooperative

Selfish

Messy

Generous

Lazy

Careless, reckless

Affectionate

Avoids adults

Short attention span

Frequent injuries

Sexual acting out

Frequent daydreams

Psychiatric problems

Tics or twitch

Overactive

Talks back

Easy going

Poor hygiene

Passive aggressive

Friendly

Clumsy

Imaginary friends

Enthusiastic

Slow moving

Attachment to dolls

Confident

Difficulty sleeping

Fearful

Impulsive

Bedwetting

Thumb sucking

Suicidal

Soiling

Teeth grinding

Obedient

Poor appetite

Head banging

Overweight

Weight loss

Angry

Defiant

Separation anxiety

Excessive masturbation

Quarrels

Often ill

Oppositional

Bullies, teases

Aggressive

Listens to reason

Good coordination

Nightmares

Explain any of the above:

Sexual Orientation:

How is problem behavior handled?

Do you find this successful?

What are your family's favorite activities?

What does your child do with unstructured time?

Has your child experienced death? (friends, family pets, etc.) _____ At what age? _____

Has there been any other significant changes or events in your child's life? (family, move, fire, etc.)

Any additional information that you feel would assist us in understanding your child?

COUNSELING/PRIOR TREATMENT HISTORY

	Yes	No	When	Where	Briefly Describe
Psychological Counseling					
Suicidal Thoughts/Gesture					
Drugs/Alcohol Treatment					
Hospitalizations					

Form Completed By (Signature)

Date

Relationship to Child/Adolescent

Charles D. Mills, Ph.D.
Licensed Psychologist

Date

Physical Exam: required not required

Comment:
