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:	**Names**	**Age**	**Sex**	**Grade**	**(at home or away)**
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

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

_____

_____

CHIILD'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:

☐ Breast Fed	☐ Milk Allergies	☐ Vomiting	☐ Diarrhea
☐ Bottle Fed	☐ Rashes	☐ Colic	☐ Constipation
☐ Not cuddly	☐ Cried a lot	☐ Rarely cried	☐ Overactive
☐ Resisted solid food	☐ Difficult to feed	☐ Trouble sleeping	☐ 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:

☐ Abortion	☐ Ear infections	☐ Multiple Sclerosis	☐ Scarlet Fever
☐ Asthma	☐ Eczema	☐ Mumps	☐ Seizures
☐ Blackouts	☐ Encephalitis	☐ Muscular Dystrophy	☐ Severe Colds
☐ Bronchitis	☐ Fevers	☐ Nose Bleeds	☐ Severe Head Injury
☐ Cerebral Palsy	☐ Hay fever	☐ Other skin rashes	☐ Thyroid disorders
☐ Chicken Pox	☐ Heart Trouble	☐ Paralysis	☐ Vision Problems
☐ Croup	☐ Hives	☐ Pleurisy	☐ Wear Glasses
☐ Diabetes	☐ Influenza	☐ Pneumonia	☐ Whooping Cough
☐ Diptheria	☐ Measles	☐ Polio	☐ Dizziness
☐ Meningitis	☐ Pregnancy	☐ Ear Aches	☐ Miscarriage

☐ Rheumatic Fever ☐ 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. Date
Licensed Psychologist

Physical Exam: ☐ required ☐ not required

Comment:

_____

_____