# CLIENT'S PERSONAL HISTORY FOR A MINOR

*(This information is necessary for our files and is strictly confidential)*

## A. PARENT/GUARDIAN INFORMATION:

Name: ____________________________________________ Date: ____________________

Date of Birth: ____________________ Age: ________ Relationship to Client: ____________________

How long have you lived in this state? ________ In this country? ________ Do you move often/seldom? __________

Occupation: ____________________ Employer: ____________________ Length at Job: __________

Religious Preference: ________________________________________ Church Member: YES NO

If you attend church, what is the church name? ________________________________________

Marital Status: SINGLE ENGAGED MARRIED SEPARATED REMARRIED DIVORCED WIDOWED

Length of Current Marriage: ____________________ Number of Marriages: ____________________

Spouse's Name: ________________________________________ Age: __________

Spouse's Occupation: ________________________________________ Length at Job: __________

Child's Name: ________________________________ Age: ________ Gender: MALE FEMALE

Child's Name: ________________________________ Age: ________ Gender: MALE FEMALE

Child's Name: ________________________________ Age: ________ Gender: MALE FEMALE

Child's Name: ________________________________ Age: ________ Gender: MALE FEMALE

What concerns have brought you to counseling? ________________________________________

______________________________________________________________________

Where are your concerns causing the most problems for you? *(Please circle ALL that apply)*

HOME WORK MARRIAGE RELATIONSHIP WITH OTHERS GOD

What concerns about you have others identified? ________________________________________

______________________________________________________________________

Please rate the severity of your current concerns on the following scale:

0 1 2 3 4 5 6 7 8 9 10

MILD MODERATE SEVERE INCAPACITATING

Are you now or have you in the past seen another counselor about your concerns, please explain? ______________

______________________________________________________________________

## B. CHILD/ADOLESCENT QUESTIONNAIRE:

Client's Name: ______________________________________________________________

School: ___________________________________________________________ Grade: ___________________

**Family Composition**

List by name member of the child's family in order of age, beginning with the older parent first, including, mother, father, brothers, and sisters of child. Please include half-sisters and half-brothers, stepparents, stepbrothers, and stepsisters.

| Member | Age | Date of Birth | Relationship | Lives in Home | Occupation and Level of Education |
|---|---|---|---|---|---|
| | | | | YES<br>NO | |
| | | | | YES<br>NO | |
| | | | | YES<br>NO | |
| | | | | YES<br>NO | |
| | | | | YES<br>NO | |
| | | | | YES<br>NO | |
| | | | | YES<br>NO | |

Parent's Marital Status: SINGLE MARRIED SEPARATED WIDOWED DIVORCED

**Medical and Developmental History**

This is a very important section of our study for the child. The information you provide is confidential.

1. Was the child adopted? __________ If yes: At what age? _________ Does he/she know? ____________
2. Immunizations current? ___________ *(please provide copy of his/her immunization records)*
3. Current health problems? ______________________________________________________________________
4. Pediatrician or family physician: ________________________________ Date last seen: __________________

**Before Birth**

Were any of the following conditions present during the mother's pregnancy? *(Circle all that apply)*

HIGH BLOOD PRESSURE USE OF NON-PRESCRIBED DRUGS ALCOHOL CONSUMPTION BLEEDING

SMOKING CIGARETTES NAUSEA HEADACHES ACCIDENTS SWELLING VOMITING

INFECTIONS CONVULSIONS DIABETES ANEMIA

What were the stressors during pregnancy? ______________________________________________________________

Total weight gain: _______________________ Length of pregnancy: _________________________________________

List all medications taken during pregnancy: ______________________________________________________________

Was the pregnancy planned? ____________________ Was the pregnancy desired? ____________________________

**At Birth**

Type of anesthesia: _________________________ Type of delivery: NATURAL FORCEPTS CESAREAN

Did the baby have any of the following problems: *(Circle all that apply)*

RESUSCITATION REQUIRED BORN AT HOME INCUBATION BREATHING BLEEDING INFECTION

COLIC JAUNDICE OTHER: ______________________________________________________________________

Birth Weight: _______ lbs. _______oz. Length: _______in. Hospital/Location: ________________________________

**Infancy and Early Childhood**

From birth to age three, who was the child's primary caretaker? ______________________________________________

Were there periods the caretaker was away from the child? YES NO If yes, how long? ___________________

Who care for the child during this period? _________________________________________________________________

Did the primary caretaker experience any of the following significant difficulties during the period? _________________

If the caretaker worked outside the home, who cared for the child? ___________________________________________

Was the child a cuddly baby? YES NO Irritable baby? YES NO

At what age did the child: Sit Alone _____ Crawl _____ Walk _____ Stay dry during the night _____

Stay dry during the day _____ Speak several words together _____ Sleep through the night _____

Not soil underwear _____ Speak in sentences _____

**Childhood**

Describe the child's temperament or disposition: __________________________________________________________

Describe the mother's temperament or disposition: _________________________________________________________

Describe the father's temperament or disposition: _________________________________________________________

Which best describes the child's development? SLOW FAST NORMAL
What is your opinion of the child's intelligence BELOW AVERAGE AVERAGE ABOVE AVERAGE

Additional Comments: ________________________________________________________________________________

At what age did the child ride a: standard bicycle? _______ bicycle without training wheels? _______

Does the child wet the bed or his/her pants? If so, how often? ___________________________________________________

Does the child soil his/her pants? If so, how often? _____________________________________________________________

Does the child know how to: *(Circle all that apply)* BRUSH TEETH DRESS SELF USE TOILET WITHOUT HELP

MAKE BED COMB HAIR TIE SHOES TELL TIME (NON-DIGITAL)

**Sexual Development**

Age at onset of menstruation? ______________ Has menses been regular? _______________________________________

Has child had sex education? If yes, by whom? ________________________________________________________________

Have there been problems in the sexual adjustment of the child? If yes, please explain. _____________________________

__________________________________________________________________________________________________

Has the child been sexually abused? If yes, when and by whom? ________________________________________________

**School History**

Did the child attend preschool? If yes, at what age? ____________________________________________________________

Child entered the first grade at what age? _____ Is the child in Special Education? If yes, since what grade? __________

Has the child ever repeated a grade(s)? If yes, what grade(s)? ___________________________________________________

How many schools has your child attended? _______ Is your child currently experiencing difficulty in school? If yes,

please explain: _________________________________________________________________________________________

**Juvenile History**

Does the child care about the rights of others? _______ Does the child like making others angry? _______

Does the child break rules on purpose? _______ Does the child like to do the opposite of what they are told? _______

Is the child disobedient? _______ Has the child ever had problems involving the police or juvenile authorities? If yes,

please explain and give the name of the child's probation officer: ________________________________________________

__________________________________________________________________________________________________

**Family History**

Has any other member of the child's family:

1. Received psychiatric or mental health treatment? If yes, who? ___________________________________________
2. Received drug and/or alcohol treatment? If yes, who? __________________________________________________
3. Received psychiatric medication? *(Including tranquilizers and antidepressants)* If yes, who? _____________________________
4. Been on probation? If yes, who? _____________________________________________________________________
5. Been placed in jail? If yes, who? _____________________________________________________________________
6. Been place in prison? If yes, who? ___________________________________________________________________

**Religious History**

Child's religion: _________________________ Child attends church: REGULARLY OCCASIONALLY SELDOM NEVER

Has there been a recent change in religious beliefs? ____________ Is religion important to the child? ________________

How important is religion to the child's family? _________________________________________________________________

**Presenting Problems**

What are the problems that caused you to seek help for the child? ________________________________________________

_____________________________________________________________________________________________________

Did anything happen at the same time these problems began that may have caused these problems? If yes, please

explain? _____________________________________________________________________________________________

Was there ever a time when these problems were better? If yes, please explain? ___________________________________

_____________________________________________________________________________________________________

How long have these problem existed with the child? _________________________________________________________
Has the child ever seen another individual(s) or agency with regard to these problems? If yes, please give us the name of

the individual/agency: _________________________________________________________________________________

Have medications ever been prescribed for these problems? If yes please list the medication name and the dosage:

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

**C. <u>SYMPTOM QUESTIONNAIRE:</u>**

The Mind of Christ Counseling Center

Listed below are items concerning children's behavior or the problems they sometimes have. Read each item carefully and decide how much your child has been bothered by this problem during the past **MONTH**. Indicate your choice by placing a check mark in the appropriate column to the right of each item. PLEASE ANSWER ALL QUESTIONS.

| **OBSERVATIONS** | **NOT AT ALL** | **SOMEWHAT** | **PRETTY MUCH** | **VERY MUCH** |
|---|---|---|---|---|
| **Problems with Eating** | | | | |
| Picky and Finicky | | | | |
| Will Not Eat Enough | | | | |
| Overeats | | | | |
| **Problems with Sleeping** | | | | |
| Restless | | | | |
| Nightmares | | | | |
| Awakens at Night | | | | |
| Cannot Fall Asleep | | | | |
| **Fears and Worries** | | | | |
| Afraid of New Situations | | | | |
| Afraid of People | | | | |
| Afraid of Being Alone | | | | |
| Worries About Illness/Death | | | | |
| **Muscular Tension** | | | | |
| Gets Stiff and Rigid | | | | |
| Twitches, Jerks, Etc. | | | | |
| Shakes | | | | |
| Stuttering | | | | |
| Difficult to Understand | | | | |
| **Wetting** | | | | |
| Wets Bed | | | | |
| Runs to Bathroom | | | | |
| **Bowel Problems** | | | | |
| Soils Self | | | | |
| Holds Back Bowel Movements | | | | |

| **OBSERVATIONS** | **NOT AT ALL** | **SOMEWHAT** | **PRETTY MUCH** | **VERY MUCH** |
|---|---|---|---|---|
| **Complains of the Following Although Doctors Cannot Find Anything Wrong** | | | | |
| Headaches | | | | |
| Stomach Aches | | | | |
| Vomiting | | | | |
| Aches and Pains | | | | |
| Loose Bowels | | | | |
| **Problems of Fidgetting** | | | | |
| Sucks Thumb | | | | |
| Bites or Picks Nails | | | | |
| Chews on Clothes, Blankets, Etc. | | | | |
| Picks at Things such as Hair, Clothing, Etc. | | | | |
| **Childish or Immature** | | | | |
| Does Not Act His/Her Age | | | | |
| Cries Easily | | | | |
| Wants Help Doing Things He/She Should Do Alone | | | | |
| Clings to Parents or Other Adults | | | | |

| Baby Talks | | | | |
|---|---|---|---|---|
| **Trouble With Feelings** | | | | |
| Keeps Anger to Self | | | | |
| Lets Himself/Herself Get Pushed Around By Other Children | | | | |
| Unhappy | | | | |
| Carries A Chip on His/Her Shoulder | | | | |
| Bullying | | | | |
| Bragging and Boasting | | | | |
| Sassy to Adults | | | | |
| **Problems Making Friends** | | | | |
| Shy | | | | |
| Afraid They Do Not Like Him/Her | | | | |
| Feelings Hurt Easily | | | | |
| Has No Friends | | | | |
| **Problems With Siblings** | | | | |
| Feels Cheated | | | | |
| Mean | | | | |
| Fights Constantly | | | | |
| **Problems Keeping Friends** | | | | |
| Disturbs Other Children | | | | |
| Wants to Run Things | | | | |
| Picks on Other Children | | | | |
| **Activity** | | | | |
| Restless or Overactive | | | | |
| Excitable/Impulsive | | | | |
| Fails to Finish Things He/She Starts | | | | |
| Short Attention Span | | | | |
| Difficulty Remaining Seated During Meal Times | | | | |

| OBSERVATIONS | NOT AT ALL | SOMEWHAT | PRETTY MUCH | VERY MUCH |
|---|---|---|---|---|
| **Temper** | | | | |
| Temper Outbursts, Explosive and Unpredictable Behavior | | | | |
| Throws Himself/Herself Around | | | | |
| Throws and Breaks Things | | | | |
| Pouts and Sulks | | | | |
| **Sexuality** | | | | |
| Plays with His/Her Own Sex Organs | | | | |
| Involved in Sexual Play With Others | | | | |
| Modest About His/Her Body | | | | |
| **School** | | | | |
| Has Difficulty Learning | | | | |
| Does Not Like to go to School | | | | |
| Is Afraid to go to School | | | | |
| Daydreams | | | | |
| Truancy | | | | |
| Will Not Obey School Rules | | | | |
| **Lying** | | | | |
| Denies Having Done Wrong | | | | |
| Blames Others For His/Her Mistakes | | | | |
| Tells Stories Which Did Not Happen | | | | |
| **Stealing** | | | | |
| From Parents | | | | |
| At School | | | | |
| From Stores and Other Places | | | | |
| **Fire Setting** | | | | |
| Sets Fires | | | | |
| **Trouble with Police** | | | | |
| Gets Into Trouble with Police | | | | |
| **Perfectionism** | | | | |
| Everything Must be Just So | | | | |
| Things Must be Done the Same Way Every Time | | | | |
| Sets Goals Too High | | | | |
| **Additional Problems** | | | | |
| Inattentive/Easily Distracted | | | | |
| Constantly Fidgeting | | | | |
| Cannot be Left Alone | | | | |
| Always Climbing | | | | |