Name _____
Date of Birth _____

CHILD DEVELOPMENTAL BACKGROUND

Current Situation

Why have you brought your child/adolescent for counseling? How long has this been a problem? Why have you done, or are doing, to resolve the problem(s)? What do you hope to accomplish with counseling?

_____

_____

_____

_____

_____

_____

Custody Status

Please check all that apply.

❑ Birth parents ❑ Adopted: Age at adoption _____ ❑ Mother only ❑ Father only
❑ Separated/Divorced, Shared parenting ❑ Ward of the court ❑ Other relative, specify: _____

If parents are divorced or never married, what is the frequency of contact between non-custodial parent and your child/adolescent? _____

Health History

Date of birth _____

Were the pregnancy, birth, and delivery of this child/adolescent ❑ Normal ❑ Problematic ❑ Do not know

If problems please describe: _____

_____

Overall, your child's early development was ❑ slow ❑ normal ❑ rapid ❑ do not know

During the first three years of life, did your child frequently exhibit any problematic behavior(s)? ❑ Yes ❑ No ❑ Do not know

Name and address
Pediatrician/Primary Care Physician: _____

_____

Telephone: _____ _____

Date last seen by physician? _____ Current height _____ Weight _____

Are childhood immunizations up to date? ❑ Yes ❑ No ❑ Do not know

Does your child have any food/drug allergies?
❑ Yes ❑ No ❑ Do not know If yes, specify: _____

How would you describe the nutritional value and balance of your child's/adolescent's diet? ❑ Good ❑ Fair ❑ Poor

Name _____

Has your child/adolescent been diagnosed with and/or currently being treated for any significant health problems? ❑ Yes ❑ No ❑ Do not know
If yes, please indicate conditions:

Has your child/adolescent had a significant appetite change over the past month? ❑ Yes ❑ No ❑ Do not know

Comments: _____

Check any problems you have observed:
❑ Dieting ❑ Excessive exercise
❑ Unusual eating habits ❑ None

Comments: _____

Has your child experienced any sleep disturbance in the past month? ❑ Yes ❑ No ❑ Do not know

Comments: _____

Is your child/ adolescent taking any medication (prescription, over-the-counter, vitamins, herbs, supplements) for emotional, learning, behavioral problems or other medical purposes? ❑ Yes ❑ No ❑ Do not know
If yes, please indicate:

Medication/Purpose:	Medication/Purpose:	Medication/Purpose:
_____	_____	_____
_____	_____	_____

Please answer the following questions to the best of your knowledge about your child/adolescent:

Yes	No	Uncertain	
❑	❑	❑	Sexually active
❑	❑	❑	Uses contraceptives
❑	❑	❑	Has history of pregnancy
❑	❑	❑	Has history of abortion
❑	❑	❑	Has fathered a child

Do you have any concerns regarding your child/ adolescent's sexual development or sexual orientation? ❑ Yes ❑ No

Comments: _____

Behavioral Health History

Has your child/adolescent had prior mental health services, counseling and/or alcohol/drug treatment?
❑ Yes ❑ No ❑ Do not know If yes, please complete the information below:

Outpatient:		Inpatient:	
Therapist/Program	Date	Hospital	Date
_____	_____	_____	_____
_____	_____	_____	_____

Has your child/adolescent (check all that apply):
❑ physically harmed another individual, pet, or small animal?
❑ threatened to physically harm anyone?
❑ talked about or attempted suicide?
❑ none of the above
❑ started a fire?
❑ run away from home?
❑ cut or mutilated their body?

Has your child/adolescent ever experienced or witnessed:
❑ rape/sexual assault? ❑ emotional abuse?
❑ other significant trauma?
❑ domestic violence?
❑ physical abuse?
❑ none of the above

Name _____

Check areas of difficulty your child/adolescent displays when performing daily activities:

- ❑ adapting to changes
- ❑ goal setting
- ❑ attending to tasks
- ❑ learning
- ❑ performing self care (grooming, hygiene, bathing etc)
- ❑ following a routine
- ❑ problem solving
- ❑ none of the above
- ❑ other. Please explain:

Cultural/Ethnic/Spiritual

Cultural/ethnic/racial issues that need consideration? ❑ Yes ❑ No
If yes, please explain: _____

Religious/spiritual issues that need consideration? ❑ Yes ❑ No
If yes, please explain: _____

Significant Events

Check any that have occurred in your child/adolescent's life.

- ❑ change of school
- ❑ death in family
- ❑ divorce or separation
- ❑ move to a new place
- ❑ frightening experience for child/adolescent
- ❑ loss of someone close to child/adolescent
- ❑ serious illness or injury to family member/friend
- ❑ other _____
- ❑ none of the above

Education

School presently attending _____ Grade _____

Parents' highest grade completed: Mother _____ Father _____

School related issues: (check all that apply)

- ❑ academic problems
- ❑ met with school counselor
- ❑ advanced a grade
- ❑ peer relationships
- ❑ relationship with teacher(s)
- ❑ behavior
- ❑ attendance
- ❑ required special help
- ❑ homework
- ❑ detention
- ❑ suspension/expulsion
- ❑ held back a grade
- ❑ transportation
- ❑ tested by school psychologist (ADD, ADHD, other)
- ❑ none of the above

Describe involvement in activities outside the home (work, hobbies, sports, volunteer activities, etc):

Family/Current Living Situation

List all the people who are currently living in the household:

Name	Age	Relationship to child/adolescent

Name _____

List sibling(s) not living in the household:

Name	Age	Relationship to child/adolescent

Is your child/adolescent experiencing any problems in relationships with: (check all that apply)

- ☐ child care providers
- ☐ father
- ☐ mother
- ☐ siblings
- ☐ stepfather
- ☐ stepmother
- ☐ step-siblings
- ☐ none of the above
- ☐ Other Explain: _____

Have any family members had problems with substance abuse (drugs, alcohol) or with mental/emotional problems? ☐ Yes ☐ No ☐ Do not know

FINANCIAL

Are there family financial concerns? ☐ Yes ☐ No ☐ Do not know
Explain: _____

Alcohol and Drug

Describe what you know about you child/adolescent's alcohol/tobacco/drug use:

Have others expressed concern about your child's/adolescent's alcohol/tobacco/drug (including caffeine) use?
☐ Yes ☐ No ☐ Do not know If yes, explain: _____

Has your child/adolescent ever experienced any of the following with his/her use of alcohol, tobacco, prescription medications or other drugs?

- ☐ change in peers
- ☐ relationship problems
- ☐ school problems
- ☐ work problems
- ☐ legal problems
- ☐ stealing from family/friends
- ☐ mood swings
- ☐ emotional problems
- ☐ giving up previously enjoyed activities
- ☐ physical problems
- ☐ withdrawal symptoms
- ☐ memory lapse after use
- ☐ increased frequency/quantity of use
- ☐ caffeine abuse
- ☐ none of the above

LEGAL

Has your child/adolescent ever had Involvement with the legal system? ☐ Yes ☐ No ☐ Do not know
Explain: _____

Are there any legal problems (or proceedings pending) having to do with other family members? ☐ Yes ☐ No ☐ Do not know
Explain:

_____ _____
Signature of Parent/Guardian Completing Form Date

_____ _____
Reviewed/Updates by Clinician Date