HERON RIDGE ASSOCIATES, PLC
CHILD/ADOLESCENT PERSONAL HISTORY FORM

Please fill out this form as completely as possible. If question does not apply, mark 'N/A'

Child's Name: _____ Case Number: _____

Birthdate: ____/_____/_____ Person Completing Form: _____ Relationship to Child: _____

Address: _____

_____

City State Zip Code

Phone: Home: _____ Cell/Work: _____

What are the problems that your child is having? _____

_____

How does your child feel about being here? _____

Previous Counseling? (outpatient or inpatient, where, when) _____

_____

What would you like your child to gain from counseling? _____

_____

Describe any problems which occurred in your child's family relating to:

Alcohol / drug use: _____

Trauma or witnessing of Violence, Sexual / Physical / Emotional Assault and/or Abuse:_____

_____

Family	Name	Age	Employer/School	Marital Status
Mother				
Father				
Step Parent/s				
Siblings				

Others living in the home:_____

Please check any of the following that describe how you believe your child has been feeling lately:
___ sad ___ anxious ___ depressed ___ frightened ___ guilty ___ angry ___ ashamed ___ aggressive ___ resentful
___ worthless ___ tearful ___ irritable ___ confused ___ extreme ups / downs ___ jealous ___ hopeless ___ helpless

Describe any behaviors your child has demonstrated that cause concern: _____

_____

Has your child had any change in sleeping habits? Yes ( ) No ( ) Describe: _____

Has your child had any change in eating habits? Yes ( ) No ( ) Describe: _____

_____

Has your child ever considered suicide in connection with his / her **current** problem? Yes ( ) No ( )

Has your child **attempted suicide recently** or in the **past**? Yes ( ) No ( )

If so, please give a brief description with dates: _____

_____

Has your child tried to hurt others or animals recently in the past? Yes ( ) No ( )

If yes, please explain: _____

Please describe what activities your child participates in: _____

_____

Who is in your child's support network?: _____

_____

CULTURAL / ETHNIC / RACIAL BACKGROUND

What is the ethnic/racial group of the parents? (Hispanic, African American, etc.)

_____

Does the child identify with this same group or another? Yes ( ) No ( )

Please explain: _____

SCHOOL ADJUSTMENT

School District: _____ School: _____

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

Present Grade: _____ Repeated Grade? _____ Present Grades? _____

Has your child ever had difficulties with: Math_____ Reading: _____ Language: _____ Speech_____
Has your child ever had special education services? Yes ( ) No ( )
Have you received any complaints from your child's school about behavior or achievement? ( ) No ( ) Yes, please explain

_____

How does your child relate to peers? _____

LEISURE

How does your child spend free time? (interests or hobbies)_____

_____

Please describe your child's level of physical activity? _____

How much time does your child play on the computer, watch TV, or play video games: _____

_____

ADJUSTMENT DIFFICULTIES

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

_____ Does not feel liked
_____ Feels Lonely
_____ Shy with children
_____ Shy with adults
_____ Prefers to be alone
_____ Worries
_____ Moody
_____ Sad
_____ Cries easily
_____ Expects failure
_____ Does not share
_____ Lacks motivation
_____ Sexual acting out
_____ Preoccupied with sexual thoughts
_____ Tics or twitches
_____ Compulsive behavior
_____ Ritualistic behavior
_____ Talks impulsively
_____ Acts impulsively
_____ Feelings of guilt
_____ Does not like self
_____ Easy to anger
_____ Stubborn
_____ Defiant
_____ Bedwetting-present
_____ Bedwetting-past
_____ Soiling
_____ Unusual thinking
_____ Unusual behavior
_____ Violent behavior
_____ Destructive to property
_____ Not always truthful
_____ Fails to understand consequences

Aggressive With:
_____ Peers
_____ Siblings
_____ Adults
_____ Needs the last word
_____ Stealing from home
_____ Stealing from peers
_____ Will not admit blame
_____ Sets fires
_____ Poorly organized
_____ Clumsy
_____ Takes unnecessary risks
_____ Short attention span
_____ Daydreams
_____ Jealousness
_____ Overactive
_____ Poor Hygiene
_____ Sleep difficulties
_____ Sleep walking

_____ Environmental Surroundings, please explain: _____

PERSONAL ADJUSTMENT

How does the child relate to: Mother? _____ Father?_____

A Step-Parent? _____ Their Siblings?_____

Authority Figures? _____

Who does your child reach out to naturally for support or resources?_____
Does your child experience any developmental, academic or behavioral problems while in school or daycare, with peers or teachers?
Yes ( ) No ( ) If yes, please explain: _____

_____

Does your child consider anyone else to be a "parent" in his/her life? YES ( ) NO ( ) If so, whom? _____

Describe your relationship with your child:

Currently: _____

_____

In the past: _____

_____

HEALTH QUESTIONNAIRE Height: _____ Weight: _____

Now	Past	NEUROLOGICAL	Now	Past	BLOOD
		Stroke ADD or ADHD Headaches Seizures Injury Sleep Disturbance Dizziness Fainting Tics			Disease AIDS Anemia Venereal Disease Mononucleosis Hepatitis
		DIGESTION			OTHER
		Stomach Pain Constipation Diarrhea Diabetes Frequent Urination Bed Wetting Overeating Under eating Vomiting Nausea Bleeding Flood Allergies			Heart Disease Drug Abuse Alcoholism Pain Disorder Cancer Kidney Disease Thyroid Disorder Tobacco Use/Abuse Physical Disorders/ Disabilities Please Specify:
		RESIRATORY			SPECIAL SENSES
		Asthma Allergies Bronchitis Pain Pneumonia			Hearing Disorder Visual Disorder Speech Disorder

Current medications being taken:

1) _____ Dosage / Freq _____ Start Date: _____ Purpose: _____

2) _____ Dosage / Freq _____ Start Date: _____ Purpose: _____

3) _____ Dosage / Freq _____ Start Date: _____ Purpose: _____

4) _____ Dosage / Freq _____ Start Date: _____ Purpose: _____

Prescribed by: _____

Medication Allergies:_____

Has your child ever been hospitalized for medical or psychiatric reasons? ( ) No ( ) Yes,

Hospital	Month / Year	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any important medical history, chronic ailments, or other health problems your child experiences: _____

_____

_____

Present Medications/supplements that do not need a prescription:_____

If taking medications/supplements how do you feel they are working for child_____

Does your child have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: _____

Describe any other health problems or important medical history about your child's immediate family members and close relatives, including chronic ailments: _____

COUNSELING/PRIOR TREATMENT HISTORY

Have you had psychotherapy/counseling before? [ ] Yes [ ] No If 'Yes' Where:

NAME OF CENTER DATES ATTENDED

1._____

Type of service: [ ] Outpatient [ ] Inpatient [ ] Day Treatment

Was this for alcohol or other drug use? [ ] Yes [ ] No

Why did you stop going to therapy?_____

_____

NAME OF CENTER DATES ATTENDED

2._____

Type of service: [ ] Outpatient [ ] Inpatient [ ] Day Treatment

Was this for alcohol or other drug use? [ ] Yes [ ] No

Why did you stop going to therapy?_____

CHEMICAL USE HISTORY (As Applicable)

Please check any of the following risk-taking behaviors you have engaged in:
___ street racing ___ gang involvement ___ skip school ___ dropped out ___ dangerous dieting ___ cutting ___ stealing
___ unprotected sex ___ running away ___ bullying others ___ fire starting ___ hurt animals ___ over exercise
___ restrict or restricted food intake

Please check any of the following alcohol /drugs that you currently or have previously used:
___ LSD ___ Spice ___ beer ___ wine ___ hard liquor ___ pot ___ cocaine ___ heroin ___ Ecstasy ___ speed
___ over the counter drugs ___ prescription drugs ___ ice ___ Triple C's ___ dones ___ quad bars ___ Special K

SUBSTANCE	METHOD OF USE AMOUNT	AGE OF FIRST USE	AGE OF REG USE	AGE OF LAST USE	USED IN LAST 48 HRS	USED IN LAST 30 DAYS
Alcohol						
Barbiturates						
Valium/Librium						
Cocaine/Crack						
Heroin/Opiates						
Marijuana						
PCP/LSC/Mesc.						
Inhalants						
Caffeine						
Nicotine						
Over-Counter						
RX Drugs						
Other Drugs						

SUBSTANCE PREFERENCE

1. _____2._____

Describe when and where you typically use_____

_____

Describe any changes in your use patterns:_____

_____

Do you use to build up your confidence? [ ] Yes [ ] No

Describe who or what has helped you:_____

Who in your family (present/past) has had a problem with drugs or alcohol?_____

Have you had withdrawal symptoms when trying to stop drinking/using? [ ] Yes [ ] No

Does your temperament change when you drink/use? (describe): _____

Has Alcohol/drugs created a problem for your job? [ ] Yes [ ] No

If 'Yes' describe: _____

PRESENT HEALTH

Physician:_____ Phone Number: _____

Address: _____

Date of Last Exam:_____ Results:_____

Are your child's immunizations up to date per recommendation of physician? ( ) YES ( )NO, explain_____

Has your child had an eye exam?_____ Glasses?_____

Has your child had a hearing exam?_____ Results:_____

Has your daughter begun menstruation?_____ Age at onset?_____

What is your child's present health?_____

Past Health Problems: Hospitalizations, Accidents, Abortion, or a Handicap?_____

BIRTH AND DEVELOPMENT

Pregnancy: Normal?_____ Complications?_____ Explain:_____

Prenatal exposure to (circle) alcohol tobacco drugs, specify_____

Length of Labor:_____ Premature?_____ weeks Weight_____

Newborn's Health_____

Infancy: Any Problem Areas?

_____ Colic
_____ Eating
_____ Sleeping
_____ Milk or Food Allergies
_____ Sleep Patterning
_____ Overactive
_____ Underactive
_____ Infections
_____ Fussy
_____ Cried Often
_____ Constipation
_____ Chronic Illness
_____ High Fevers
_____ Hospitalization
_____ Surgery
_____ Slow Growth

EARLY CHILDHOOD

Indicate Age Started:

Talking: Single Words at_____ months, sentences at _____ months. Walking at _____ months

Began Toilet training at _____ months, completed toilet training at _____ months.

Knew colors at _____ months Knew numbers at _____ months. Knew letters at _____ months

RELIGIOUS AND SPRITUAL BELIEFS

Mother's background _____

Father's background:_____

Does the family practice a religion or spirituality? Please Describe:_____

Does your child participate?_____

LEGAL

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

_____

On Probation?_____

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

Is your child adopted?_____ When were they told?_____

FAMILY INCOME INFORMATION

Does your child work?_____ Hours:_____ Position:_____

Family's Yearly Income?_____ Financial Difficulties?_____

Thank you for your completion of this form.

YOUR SIGNATURE:_____ DATE:_____

STAFF USE ONLY

_____ _____
Therapist signature/credentials Date

M.D./D.O. Comments:_____

_____

Physical Exam: [ ] is required [ ] is not required

_____ _____
Physician signature/credentials Date

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