Mental Health Clinic of Greenville
PO Box 377; Greenville, TX 75403
301 Interstate Highway 30, Suite 100, Greenville, TX 75402
Phone: 903-274-4140 Fax: 877-310-9115

PERSONAL HISTORY FORM – CHILD/ADOLESCENT (<18)

Client's name: _____ Date: _____

Gender: ____F ____M Date of birth: _____ Age: ____ SSN _____

Form completed by _____

If you need more space for the following questions, please use the back of the sheet.
Primary reason(s) for seeking services:

____ Anger management ____ Anxiety ____ Coping ____ Depression

____ Addictive behaviors ____ Fear/phobias ____ Mental confusion ____ Sexual concerns

____ Sleeping problems ____ Eating disorder____ Alcohol/drugs ____ Hyperactivity

____ Other mental health concerns (specify): _____

Is there a lawsuit or custody suit pending, or is there a probability of a lawsuit being filed regarding the problem for which you are seeking counseling? Yes ____ No ____
If yes, please explain: _____

FAMILY HISTORY

Current Parental Marital Status: Married to each other for ____years;
Separated for ____ years Divorced for ____ years; Please Explain: _____

Father remarried ____ times Father involved with someone else _____

Mother remarried ____ times; Mother involved with someone else_____

If divorced or separated, who has legal custody? _____

Were the child's/adolescent's parents ever married? _____Yes _____No

CLIENT'S MOTHER

Name: _____ Date of birth: _____ Occupation: _____

Where employed: _____ Work phone: _____FT ___PT ___

Mother's Education: _____

Is the child/adolescent currently living with mother? _____Yes _____No

____ Natural Parent ____ Set-Parent ____Adoptive Parent ____ Foster Home

Mothers relationship with Client __Poor __Average __Good;

Other (specify): _____

Is there anything notable, unusual or stressful about the child's/adolescent's relationship with the mother?
_____Yes _____No If Yes, please explain: _____

How does the mother discipline the child/adolescent? _____

For what reasons does the mother discipline the child/adolescent? _____

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CLIENT'S FATHER

Name: _____ Date of birth: _____Occupation: _____

Where employed: _____Work phone: _____ FT ___PT__

Father's Education: _____

Is the child/adolescent currently living with father? _____Yes _____No

____ Natural Parent ____ Set-Parent ____Adoptive Parent ____ Foster Home

Fathers relationship with Client __Poor __Average __Good;

Other (specify): _____

Is there anything notable, unusual or stressful about the child's/adolescent's relationship with the father?
_____Yes _____No If Yes, please explain: _____

How does the father discipline the child/adolescent? _____

For what reasons does the father discipline the child/adolescent? _____

IMMEDIATE FAMILY CONTINUED

List all persons/family members living in client's household and all siblings:

Names of Siblings	Age	Gender	Lives	Quality of Relationship with the Client
_____	____	__F __M	__Home __Away	__Poor __Average __Good
_____	____	__F __M	__Home __Away	__Poor __Average __Good
_____	____	__F __M	__Home __Away	__Poor __Average __Good
_____	____	__F __M	__Home __Away	__Poor __Average __Good
Others living in the household			Relationship (e.g., grandparent, cousin, foster child)	
_____	____	__F __M	_____	__Poor __Average __Good
_____	____	__F __M	_____	__Poor __Average __Good
_____	____	__F __M	_____	__Poor __Average __Good
_____	____	__F __M	_____	__Poor __Average __Good

Describe any past or current significant issues in other immediate family relationships:_____

_____

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FAMILY HEALTH HISTORY

Have any of the following diseases occurred among the child's/adolescent's blood relatives (parents, siblings, aunts, uncles, or grandparents)?
Check those which apply:

___Allergies	___Deafness	___Muscular Dystrophy
___Anemia	___Diabetes	___Nervousness
___Asthma	___Glandular Problems	___Perceptual Motor Disorder
___Bleeding Tendency	___Heart Diseases	___Mental Retardation
___Blindness	___High Blood Pressure	___Seizures
___Cancer	___Kidney Disease	___Spinal Bifida
___Cerebral Palsy	___Mental Illness	___Suicide
___Cleft Lips	___Migraines	___Other (specify):_____
___Cleft Palate	___Multiple Sclerosis	_____

Comments Family Health:_____
_____

PREGNANCY/ BIRTH

Has the child's/adolescent's mother had any occurrences of miscarriages or stillborns?
___Yes ___No If Yes, describe: _____

Was the pregnancy with child/adolescent planned? ___Yes ___No
Mother's age at child's birth: _____ Father's age at child's birth: _____

Child/adolescent number: _____ of _____ total children.
How many pounds did the mother gain during the pregnancy? _____

While pregnant, did the mother smoke? ___Yes ___No If Yes, what amount: _____
Did the mother use drugs of alcohol? ___Yes ___No If Yes, what type/amount: _____

While pregnant, did the mother have any medical or emotional difficulties (e.g. surgery, hypertension, medication)? ___Yes ___No If Yes, please describe: _____
_____
Length of Pregnancy: _____ Baby's birth weight: _____ Baby's birth length: _____

Length of Labor: _____ Induced? ___Yes ___No; Cesarean? ___Yes ___No

Describe any physical or emotional complications with the delivery: _____

Describe any complications for the mother or the baby with the delivery: _____

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INFANCY/TODDLER (Check all that apply)

___Breast-fed	___Milk Allergies	___Vomiting	___Diarrhea
___Bottle-fed	___Rashes	___Colic	___Constipation
___Not Cuddly	___Cried Often	___Rarely Cried	___Overactive
___Resisted Solid Food	___Trouble Sleeping	___Irritable When Awakened	___Lethargic

DEVELOPMENT HISTORY: (Check all that apply)

Childs development was: ____Slow ____Average ____Fast

In what areas **did development veer** from normal?

Sat Alone Dressed Self took 1st Steps Tied Shoe Laces Spoke Words

Rode Two-Wheeled Bike Spoke Sentences, Toilet Trained

Weaned

Dry During Day Fed Self

Dry During Night

Compared with others in the family, child's/adolescent's development was:
____Slow ____Average ____Fast

Age for following developments were (List age below)

Began Puberty_____ Menstruation:_____ Voice Change:_____

Convulsion:_____ Breast Development:_____ Injuries or Hospitalization:_____

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

_____

EDUCATION

Current School: _____

Type of School: ___Public ___Private ___Home Schooled ___Other (specify):_____

Grade: _____ Teacher: _____

In Special Education: ___Yes ___No If Yes, describe: _____

In Gifted Program: ___Yes ___No If Yes, describe: _____

Has child/adolescent ever been held back in school? ___Yes ___No

If Yes, describe: _____

Which subjects does the child/adolescent enjoy in school? _____

Which subjects does the child/adolescent dislike in school? _____

What grades does the child/adolescent usually receive in school? _____

Have there been any recent changes in the child's/adolescent's grades? ___Yes ___No

If Yes, describe: _____

Has the child/adolescent been tested psychologically? ___Yes ___No

If Yes, describe: _____

Check all the descriptions that relate to your child/adolescent: (Parent's Opinion):

Feelings about School Work:

___Anxious ___Passive ___Enthusiastic ___Fearful

___Eager ___No Expression ___Bored ___Rebellious

___Other (describe):_____

Approach to School Work:

___Organized ___Industrious ___Responsible ___Interested

___Self-directed ___No initiative ___Refuses ___Does only what is expected

___Sloppy ___Disorganized ___Cooperative ___Doesn't complete assignments

___Other (describe):_____

Performances in School

___Satisfactory ___Underachiever ___Overachiever

___Other (describe):_____

Child's/Adolescent's Peer Relationships:

___Spontaneous ___Follower ___Leader ___Difficulty making friends

___Makes friends easily ___Long-time friends ___Shares easily

___Other (describe):_____

Who handles responsibility for your child/adolescent in the following areas?

School: ___Mother ___Father ___Shared ___Other (specify):_____

Health: ___Mother ___Father ___Shared ___Other (specify):_____

Problem Behavior: ___Mother ___Father ___Shared ___Other (specify):_____

If the child/adolescent is involved in a vocational program or works a job, please fill in the following:

How is the child's/adolescent's grades in school been affected since working?
___Lower ___Same ___Higher

How many previous jobs or placements has the child/adolescent had? _____

Usual length of employment: _____ Usual reason for leaving: _____

LEISURE RECREACTIONAL

Describe special areas of interest or hobbies (e.g. art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now? (weekly, none, ect)	How often in the past? (weekly, none, ect)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LEGAL HISTORY

_____No legal problems ____Now on probation ____Arrest(s) not substance-related

____Arrest(s) substance-related ____ Court ordered this treatment

JDC/Jail ____ how many times, total time served: ____

Describe last legal difficulty: _____

_____

Medical/Physical Health

___Abortion
___Asthma
___Blackouts
___Bronchitis
___Cerebral Palsy
___Chicken Pox
___Congenital Problems
___Croup
___Disorder
___Glandular Problems
___Diabetes
___Diphtheria
___Dizziness
___Ear Aches
___Ear Infections
___Eczema
___Encephalitis
___Fevers
___Deafness
___Spinal Bifida
___Heart Diseases
___High Blood Pressure
___Kidney Disease
___Mental Illness
___Mental Retardation
___Muscular Dystrophy
___Nervousness
___Perceptual Motor
___Seizures
___Suicide

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List any current health concerns:_____
_____

List any recent health or physical changes:_____
_____

Describe any serious hospitalizations or accidents:

Date	Age	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Nutrition (Define your current nutritional status)
Does your child eat Breakfast Lunch Dinner Snacks? Yes_____ No _____

Would you consider their food choices healthy? Yes _____ No _____

Does your child have any issues relating to nutrition? Yes _____ No _____

Please explain: _____

Most Recent Examinations (Define any concerns, problems, issues)

Type of Examination	Date of Most Recent Visit	Results
Physical Examination:	_____	_____
Dental Examination:	_____	_____
Vision Examination:	_____	_____
Hearing Examination:	_____	_____

EMOTIONAL/PSYCHIATRIC TREATMENT HISTORY

Information about child/adolescent (past and present):

	Yes	No	When	Where	Reaction or overall experience
Counseling/Psychiatric:	___	___	_____	_____	_____
Treatment:	___	___	_____	_____	_____
Suicidal thoughts/attempts:	___	___	_____	_____	_____
Drug/alcohol treatment:	___	___	_____	_____	_____
Hospitalization:	___	___	_____	_____	_____

Diagnosis _____Treatment Beneficial? _____

Has a family member had outpatient psychotherapy? Yes _____ No _____If yes, who/why (list all): _____

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Current prescribed medications	Dose	Dates	Purpose	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Has any family member used psychotropic medications? Yes_____ No _____
If yes, who/why (list all): _____

Immunization record Current _____ Not current _____

Please explain _____

SUBSTANCE USE HISTORY (Check all that apply for client)

Family alcohol/drug abuse history: ___ Father ____Mother ____Grandparent(s) -

____Sibling(s) ____Stepparent/live-in ____ Uncle(s)/Aunt(s) _____ Other

Describe: _____

Does the **child/adolescent** use or have a problem with alcohol or drugs? ___Yes ___No

If Yes, describe: _____

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BEHAVIORIAL/ EMOTIONAL

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

___Affectionate	___Frustrated Easily	___Sad
___Aggressive	___Gambling	___Selfish
___Alcohol Problems	___Generous	___Separation Anxiety
___Angry	___Hallucinations	___Sets Fires
___Anxiety	___Head Banging	___Sexual Addiction
___Attachment to Dolls	___Heart Problems	___Sexual Acting Out
___Avoids Adults	___Hopelessness	___Shares
___Bedwetting	___Hurts Animals	___Sick Often
___Blinking, Jerking	___Imaginary Friends	___Short Attention Span
___Bizarre Behavior	___Impulsive	___Shy, Timid
___Bullies,Threatens	___Irritable	___Sleeping Problems
___Careless, Reckless	___Lazy	___Slow Moving
___Chest Pains	___Learning Problems	___Soiling Self
___Clumsy	___Lies Frequently	___Speech Problems
___Confident	___Listens to Reason	___Steals
___Cooperative	___Loner	___Stomach Aches
___Cyber Addiction	___Low Self-Esteem	___Suicidal Threats/ Ideations
___Defiant	___Messy	___Suicidal Attempts
___Depression	___Moody	___Talks Back
___Destructive	___Nightmares	___Teeth Grinding
___Difficulty Speaking	___Obedient	___Thumb Sucking
___Dizziness	___Often Sick	___Tics or Twitching
___Drugs Dependence	___Oppositional	___Unsafe Behaviors
___Eating Disorder	___Over Active	___Unusual Thinking
___Enthusiastic	___Overweight	___Weight Loss
___Excessive Masturbation	___Panic Attacks	___Withdrawn
___Expects Failure	___Phobias	___Worries Excessively
___Fatigue	___Poor Appetite	___Other:_____
___Fearful	___Psychiatric Problems	_____
___Frequent Injuries	___Panic Attacks	_____

Please describe any of the above (or other) concerns: _____

How are problem behaviors generally handled? _____

_____

What are the family's favorite activities? _____

_____

What does the child/adolescent do with unstructured time? _____

_____

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Has the child/adolescent experienced death (friends, family pets, other)? ___Yes ___No

At what age? ____ If Yes, describe the child's/adolescent's reaction: _____

_____

Have there been any other significant changes or events in your child's/adolescent's life (family, moving, fire, etc.)? ___Yes ___No If Yes, describe: _____

_____

Any additional information that you believe would assist us in understanding your child/adolescent? _____

_____

_____

Any additional problems that would assist us in understanding current concerns or problems?

_____

_____

_____

_____

What are your goals for the child's/adolescent's therapy? _____

_____

What family involvement would you like to see in the therapy? _____

_____

Do you believe the child/adolescent is suicidal at this time? ___Yes ___No

If Yes, explain: _____

_____

_____