

**FAMILY/CHILD/ADOLESCENT PERSONAL DATA**



*This is a confidential record of your personal history. Information contained in it will not be released to anyone unless authorized by you or required by the law as explained in our consent to treatment.*

Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

Client: Name \_\_\_\_\_ Male Female  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Minor's Cell Phone(\_\_\_\_) \_\_\_\_\_  
May we call you at home? Y N At Work? Y N Highest Grade Completed: \_\_\_\_\_  
Person to notify in case of emergency: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Ethnicity: Caucasian African American Hispanic Asian Other  
Would minor like spirituality/religious issues to be a part of your therapy? Y / N / Don't Know

NOTE: It is important for the client and therapist to determine together what part spiritual/religious issues will or will not take in therapy.

**Minor: In your own words, please state the nature of the main problem:**

**Parent: In your own words, please state the nature of the main problem:**

How would you rate how serious this problem feels to you? (Circle one) 1 2 3 4 5  
Mildly Upsetting Extremely Serious

**What would you like to accomplish through counseling?**

I agree to be responsible for the payment of \$ \_\_\_\_\_ per session which is payable at the time of the session.

Parent/Guardian Signature \_\_\_\_\_

Therapist Initials \_\_\_\_\_

## FAMILY STATUS

**Parents:** Father: Age \_\_\_\_\_ Occupation \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Mother: Age \_\_\_\_\_ Occupation \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Marital Status of Parents:    Single    Married    Divorce    Separated    Living Together    Other  
Custody Arrangement: \_\_\_\_\_

o Step-father: Age \_\_\_\_\_ Step-mother: Age \_\_\_\_\_

If divorced, please specify minor's age at divorce and circumstances surrounding divorce: \_\_\_\_\_

Briefly describe minor's relationship with your Father: \_\_\_\_\_

With minor's mother: \_\_\_\_\_

**Siblings:** Brothers' first names: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sisters' first names: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Other:** Please explain if any member of the family has ever suffered from anything that could be described as an "emotional" or "psychological" problem: \_\_\_\_\_

Please mention any history of domestic violence, child abuse or sexual abuse in the family: \_\_\_\_\_

Please comment on any history of alcohol or drug use in the family: \_\_\_\_\_

## MINOR'S DEVELOPMENTAL HISTORY (If yes, please describe)

Pregnancy Planned:    Yes    No    Parents' Attitudes Toward Having Children: \_\_\_\_\_

Complications with Pregnancy:    Yes    No \_\_\_\_\_

Premature Birth:    Yes    No \_\_\_\_\_

Age When: Crawled: \_\_\_\_\_ Walked: \_\_\_\_\_ Spoke First Word: \_\_\_\_\_ Spoke First Sentence: \_\_\_\_\_

Developmental Delays    Yes    No \_\_\_\_\_

## MINOR'S EDUCATIONAL HISTORY (If yes, please describe)

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Type of Class:    Regular    Gifted    Other \_\_\_\_\_

School Problems:    None \_\_\_\_\_

Skipped a grade:    Yes    No \_\_\_\_\_

Held back a grade:    Yes    No \_\_\_\_\_

## MINOR'S CURRENT FUNCTIONING (If yes, please describe)

Behavioral Problems:    Yes    No \_\_\_\_\_

Problems with Parents:    Yes    No \_\_\_\_\_

Problems with Siblings:    Yes    No \_\_\_\_\_

Problems with Peer Relationships:    Yes    No \_\_\_\_\_

Substance Abuse:    Yes-    No \_\_\_\_\_

Sexually Active:    Yes    No \_\_\_\_\_

Any Cultural Considerations?    Yes    No \_\_\_\_\_

## MINOR'S MEDICAL HISTORY

Current Weight: \_\_\_\_\_ One Year Ago: \_\_\_\_\_ Maximum: \_\_\_\_\_ When: \_\_\_\_\_

Does minor exercise regularly?    Yes    No How? \_\_\_\_\_

Does minor sleep well?    Yes    No Amount (hours): \_\_\_\_\_ Easy to get to sleep?    Yes    No

What recreation does minor enjoy? \_\_\_\_\_

Physician: \_\_\_\_\_ City: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

The hardest time in minor's development was:    Preschool    Grade School    Jr. High    High School

**MINOR'S MEDICAL CONDITIONS**

**Please check all that apply to you:**

NEVER SELDOM SOMETIMES OFTEN

- Insomnia
- Loss of Appetite
- Back Pain
- Asthma
- Headaches
- Phobias (Fears)
- Nausea
- Allergies
- Nervousness
- Loss of temper
- Fatigue
- Depression
- High blood pressure
- Constipation
- Diarrhea
- Over-eating
- Mood swings

**OTHER CONCERNS**

- Smoking
  - Packs per week \_\_\_\_\_
- Alcohol Intake:
  - Frequency (per week): \_\_\_\_\_
  - How Much? \_\_\_\_\_
  - What do you drink? \_\_\_\_\_
- Marijuana
  - Amount per week: \_\_\_\_\_
- Drugs (not medications)
  - What? \_\_\_\_\_
  - Frequency: \_\_\_\_\_

**MINOR'S MEDICATION HISTORY**

**Please check all that apply to you:**

NEVER SELDOM SOMETIMES OFTEN

- Appetite Suppressants
- Pain Relievers
- Sedatives/  
Tranquilizers
- Sleep Aids
- Stimulants
- Blood Pressure Meds
- Heart Medicine
- Vitamins
- Other (please specify)

**Please list all current medications:**

Medication	Dosage	Reason

**Comments:**

**MINOR'S TREATMENT/THERAPY HISTORY**

**Has minor ever had any previous counseling or psychotherapy? Y N**

**If YES, please list from most recent:**

Problem	Dates	Therapist/Location	Was Therapy Successful?

**Has minor ever attempted suicide? Y N** If YES, when? \_\_\_\_\_  
 If YES, method used: \_\_\_\_\_

**Has minor ever been hospitalized for psychiatric reasons? Y N**  
 • If YES, when? \_\_\_\_\_ Length of hospital stay: \_\_\_\_\_

**ADDITIONAL INFORMATION**

What are minor's strengths/talents? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Following information for parent primarily responsible for payment:**

Name: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ Phone: \_\_\_\_\_