Pediatric Adolescence
Professional Psychology

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Personal History
Children and Adolescents

Client's name:_____ Date:_____

Gender:___F __M Date of birth:__Age:_____Grade in school: _____

Form completed by (if someone other than client): _____

Address:_____City:_____State:_____Zip: _____

Phone (home):_____(work):_____Ext: _____

If you need any more space for any of the following questions please use the back of the sheet.

Primary reason(s) for seeking services:

_____

_____

List major problems in daily life functioning (e.g., school failure, lack of friends, poor relationships with parents, self-esteem)

Home:_____
School:_____
Peers: _____

Others:_____

Family History

Parents

With whom does the child live at this time? _____

Are parent's divorced or separated? _____ If

Yes, who has legal custody? _____

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? Yes No

If Yes, describe: _____

Client's Mother

Name:_____Age:_____Occupation:_____FT ____PT Where employed:_____ Work phone: _____

Is the child currently living with mother? __Yes ____No

___Natural parent___Step-parent____Adoptive parent__Foster home__Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the mother?

___Yes ____No If Yes, please explain: _____
Describe overall relationship with mother? _____

Client's Father

Name:_____Age:_____Occupation:_____FT ____PT Where employed:_____ Work phone: _____
Father's education: _____ Is the child currently living with father? __Yes _____No
___Natural parent___Step-parent____Adoptive parent__Foster home_Other (specify): _____
Is there anything notable, unusual or stressful about the child's relationship with the father?
___Yes ____No If Yes, please explain: _____
Describe overall relationship with Father? _____

Client's Siblings and Others Who Live in the Household

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

Any other individuals living in the household:
_____

Developmental History

Infancy/Toddlerhood Check all which 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

Please describe if there were any areas that at your child was delayed developmentally: Cognitive Delays (learning), Motor Delays, Social, Emotional, and Behavioral Delays, Speech Delays_____
_____

Compared with others in the family, child's development was:___slow_____average_____fast

Education

Current school:_____School phone number: _____
Grade:_____

Rebbe:_____

Teachers and subjects:_____

Special Support in school (special education, P3, resource room) ?_____Yes
_____NoIf Yes, describe: _____

<u>Intelligence and Achievement Testing</u>

Has your child ever been tested for intelligence, achievement, learning problems or psychological evaluations? _____

If Yes, what type of evaluation, date of evaluation, and name of evaluator:

_____

What was the purpose of the assessment and what were the results (e.g. for special education placement)?

_____

Any diagnosed learning disabilities or disorders: _____Yes ___No

If Yes, describe: _____

If child has been tested, please share a copy of reports to Dr. Stern

Therapists (Ot, PT, Speech, P3, counseling)?_____Yes _____No

If Yes, describe: _____

Which subjects does the child enjoy in school? _____

Which subjects does the child dislike in school? _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? __Yes _____No

If Yes, describe: ___

Check the descriptions which specifically relate to your child.

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): _____

<u>Performance in School (Parent's Opinion):</u>

___Satisfactory ___Underachiever ___Overachiever

___Other (describe): _____

Child'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 in the following areas?

School: Mother ___Father ___Shared ___Other (specify): _____

Health: Mother ___Father ___Shared ___Other (specify): _____

Problem behavior: Mother Father Shared Other (specify): _____

<u>Leisure/Recreational</u>

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.)

Activities:

_____ _____ _____

How often now? _____

How often in the past? _____

Medical/Physical Health

Current prescribed medications and dose: _____

Name of Doctor: _____

Type of Doctor:_____

Purpose of Medication: _____

How often Taken:_____

Start Date:_____

Side effects:_____

Any other history of prescribed medications (name of medication, dosage, and dates taken):

_____

Counseling/Prior 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	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____

Chemical Use History

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

If Yes, describe: _____

Any other important

_____

_____