Inner Strength Counseling
Eleanor Salemi, LCSW
801 West Bay Dr., Ste. 422
Largo, FL 33770
727 418 0735

Personal History—Children and Adolescents (Under 18)

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: _____ Cell _____

Okay to leave message? Yes: ____ No: ____ email: _____

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:

_____Anger management _____Anxiety _____Coping _____Depression
_____Eating disorder _____Fear/phobias _____Mental confusion _____Sexual concerns
_____Sleeping problems _____Addictive behaviors _____Alcohol/drugs _____Hyperactivity
_____Other mental health concerns (specify): _____

_____

FAMILY HISTORY

PARENTS

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

If Yes, who has legal custody? _____

Where the child's parents ever married? ____ Yes ____ No

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: _____

Mother's education: _____

Is the child currently living with mother? ____ Yes ____ No

_____Natural parent _____Stepparent _____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:

_____

How is the child disciplined by the mother? _____

For what reasons is the child disciplined by the mother? _____

CLIENT'S FATHER

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Name: _____ Age: _____ Occupation: _____ _____ FT_____PT

Where employed: _____ Work phone: _____

Father's education: _____

Is the child currently living with father? ____ Yes ____ No

_____Natural parent _____Stepparent _____Adoptive parent _____Foster home

_____Other (specify): _____

If there anything notable, unusual or stressful about the child's relationship with the father?

_____ Yes _____ No If Yes, please explain: _____

_____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

CLIENT'S SIBLINGS AND OTHERS WHO LIVE IN THE HOUSEHOLD

Name 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., cousin, foster child)	
_____	____	____ F ____ M	_____	____ poor ____ average ____ good
_____	____	____ F ____ M	_____	____ poor ____ average ____ good
_____	____	____ F ____ M	_____	____ poor ____ average ____ good
_____	____	____ F ____ M	_____	____ poor ____ average ____ good

Comments: _____

_____

_____

FAMILY HEALTH HISTORY

Have any of the following diseases occurred among the child'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	____ Spina bifida
____ Cerebral palsy	____ Mental illness	____ Suicide
____ Cleft lips	____ Migraines	____ Other (specify): _____
____ Cleft palate	____ Multiple sclerosis	_____

____ Comments re: Family Health:

CHILDHOOD/ADOLESCENT HISTORY

PREGNANCY/BIRTH

Has the child's mother had any occurrences of miscarriages or stillbirths? ____ Yes ____ No

If Yes, describe: _____

Was the pregnancy with child planned? ____ Yes ____ No Length of pregnancy: _____

Mother's age at child's birth:_____ Father's age at child's birth: _____

Child 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, type/amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication) ____ Yes ____ No

If Yes, describe: _____

Length of labor: _____ Induced: ____ Yes ____ No Caesarean? ____ Yes ____ No

Baby's birth weight: _____ Baby's birth length: _____

Describe any physical or emotional complications with the delivery: _____

_____

Describe any complications for the mother or the baby after the birth: _____

_____

Length of hospitalization: Mother: _____ Baby: _____

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

Developmental History Please note the age at which the following behaviors took place:

Sat alone: _____	Dressed self: _____
Took 1st steps: _____	Tied shoelaces: _____
Spoke words: _____	Rode two-wheel bike: _____

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Spoke sentences: _____ Toilet trained: _____
Weaned: _____ Dry during day: _____
Fed self: _____ Dry during night: _____
Compared with others in the family, child's development was: _____ slow _____ average _____ fast
Age for following developments (fill in where applicable)
Began puberty: _____ Menstruation: _____
Voice change: _____ Convulsions: _____
Breast development: _____ Injuries or hospitalization: _____
Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

EDUCATION

Current school: _____ School phone number: _____

Type of school: ____ Public ____ Private ____ Home schooled ____ Other (specify): _____

Grade: _____ Teacher: _____ School Counselor: _____

In special education? ____ Yes ____ No If Yes, describe: _____

In gifted program? ____ Yes ____ No If Yes, describe: _____

Has child ever been held back in school? _____ 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: _____

Has the child been tested psychologically? ____ Yes _____ No

If Yes, describe: _____

Check the descriptions that specifically relate to your child.

FEELINGS ABOUT SCHOOLWORK:

____ Anxious ____ Passive ____ Enthusiastic ____ Fearful

____ Eager ____ No expression ____ Bored ____ Rebellious

____ Other (describe): _____

APPROACH TO SCHOOLWORK:

____ Organized ____ Industrious ____ Responsible ____ Interested

____ Self-directed ____ No initiative ____ Refuses ____ Does only what is expected

____ Sloppy ____ Disorganized ____ Cooperative ____ Doesn't complete assignments

____ Other (describe): _____

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PERFORMANCE IN SCHOOL (PARENT'S OPINION):

____ Satisfactory ____ Underachiever ____ Overachiever

____ Other (describe): _____

CHILD'S PEER RELATIONSHIPS:

____ Spontaneous ____ Follower ____ Leader ____ Difficulty making friends

____ Makes friends easily ____ Longtime 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): _____

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

What is the child's attitude toward work? _____ Poor _____ Average _____ Good _____ Excellent

Current employer: _____ Position: _____ Hours per week: _____

How have the child's grades in school been affected since working? ____ Lower ____ Same ____ Higher

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

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

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LEISURE/RECREATIONAL

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?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL/PHYSICAL HEALTH

____ Abortion
____ Asthma
____ Blackouts
____ Bronchitis
____ Cerebral palsy
____ Chicken pox
____ Congenital problems
____ Croup
____ Diabetes
____ Diphtheria
____ Dizziness
____ Earaches
____ Ear infections
____ Eczema
____ Encephalitis
____ Fevers
____ Hay fever
____ Heart trouble
____ Hepatitis
____ Hives
____ Influenza
____ Lead poisoning
____ Measles
____ Meningitis
____ Miscarriage
____ Multiple sclerosis
____ Mumps
____ Muscular dystrophy
____ Nosebleeds
____ Other skin rashes
____ Paralysis
____ Pleurisy
____ Pneumonia
____ Polio
____ Pregnancy
____ Rheumatic fever
____ Scarlet fever
____ Seizures
____ Severe colds
____ Severe head injury
____ Sexually transmitted disease
____ Thyroid disorders
____ Vision problems
____ Wearing glasses
____ Whooping cough
____ Other
_____

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

NUTRITION

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	____ / week	_____	____ No	____ Low	____ Med	____ High
Lunch	____ / week	_____	____ No	____ Low	____ Med	____ High
Dinner	____ / week	_____	____ No	____ Low	____ Med	____ High
Snacks	____ / week	_____	____ No	____ Low	____ Med	____ High

Comments:

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MOST RECENT EXAMINATIONS

Type of examination	Date of most recent visit	Results
Physical examination	_____	_____
Dental examination	_____	_____
Vision examination	_____	_____
Hearing examination	_____	_____

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

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

Immunization record (check immunizations the child/adolescent has received):

	DPT	Polio
2 months	____	____
4 months	____	____
6 months	____	____
18 months	____	____
4-5 years	____	____

15 months ____ MMR (Measles, Mumps, Rubella)
24 months ____ HBPV (Hib)
Prior to school ____ HepB

CHEMICAL USE HISTORY

Does the child/adolescent use or have a problem with alcohol or drugs? ____ Yes ____ No

If Yes, describe:

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	____	____	_____	_____	_____

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BEHAVIORAL/EMOTIONAL

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

____ Affectionate
____ Aggressive
____ Alcohol problems
____ Angry
____ Anxiety
____ Attachment to dolls
____ Avoids adults
____ Bedwetting
____ Blinking, jerking
____ Bizarre behavior
____ Bullies, threatens
____ Careless, reckless
____ Chest pains
____ Clumsy
____ Confident
____ Cooperative
____ Cyber addiction
____ Defiant
____ Depression
____ Destructive
____ Difficulty speaking
____ Dizziness
____ Drug dependence
____ Eating disorder
____ Enthusiastic
____ Excessive masturbation
____ Expects failure
____ Fatigue
____ Fearful
____ Frequent injuries
____ Frustrated easily
____ Gambling
____ Generous
____ Hallucinations
____ Head banging
____ Heart problems
____ Hopelessness
____ Hurts animals
____ Imaginary friends
____ Impulsive
____ Irritable
____ Lazy
____ Learning problems
____ Lies frequently
____ Listens to reason
____ Loner
____ Low self-esteem
____ Messy
____ Moody
____ Nightmares
____ Obedient
____ Often sick
____ Oppositional
____ Overactive
____ Overweight
____ Panic attacks
____ Phobias
____ Poor appetite
____ Psychiatric problems
____ Quarrels
____ Sad
____ Selfish
____ Separation anxiety
____ Sets fires
____ Sexual addiction
____ Sexual acting out
____ Shares
____ Sick often
____ Short attention span
____ Shy, timid
____ Sleeping problems
____ Slow moving
____ Soiling
____ Speech problems
____ Steals
____ Stomachaches
____ Suicidal threats
____ Suicidal attempts
____ Talks back
____ Teeth grinding
____ Thumb sucking
____ Tics or twitching
____ Unsafe behaviors
____ Unusual thinking
____ Weight loss
____ Withdrawn
____ Worries excessively
____ Other:
_____
_____

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

_____

How behavior problems are generally handled? _____

_____

What are the family's favorite activities?_____

_____

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

_____

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 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 information that would assist us in understanding current concerns or problems?

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

_____

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

_____

Do you believe the child is suicidal at this time? ____ Yes ____ No

If Yes, explain: _____

_____

FOR STAFF USE

Therapist's comments

Therapist's signature/credentials: _____ Date: _____