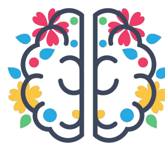

InsightCounseling
SERVICES OF GREATER LANSING, LLC

Insight Counseling Services of Greater Lansing, LLC

PERSONAL HISTORY – CHILDREN & 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: _________

Emergency contact name:__________________________________Phone: _____________________

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? ____

Were 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 __ 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: ____

____

How is the child disciplined by the mother? ____

For what reasons is the child disciplined by the 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: ____

____

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

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., 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	____ Spinal Bifida
____ Cerebral Palsy	____ Mental illness	____ Suicide
____ Cleft lips	____ Migraines	____ Other (specify): _________
____ Cleft palate	____ Multiple sclerosis	___________________________

Comments re: Family Health: ____

____

Childhood/Adolescent History

Pregnancy/Birth

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 was number ___ of ________ total children.

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: ____

Describe any physical or emotional complications with the delivery: ______________________________
____

Describe any complications for the mother or the baby after the birth: ___________________________
____

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 approximate age at which the following behaviors took place:

Sat alone: ______________________________ Dressed self: ______________________________

Took 1st steps: __________________________ Tied shoelaces: ____________________________

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 development was: ___ slow ____ average ____ fast

Age for following occurrences (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.)
____
____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? ______________________________

Are you experiencing any problems due to cultural or ethnic issues? ____ Yes _____ No

If Yes, describe: ____

Other cultural/ethnic information: ____

Spiritual/Religious

How important to your child are spiritual matters? ____ Not __ Little _______ Moderate __ Much

Is your child affiliated with a spiritual or religious group? _____ Yes ______ No

If Yes, describe: ______________________________

Is your family affiliated with a spiritual or religious group? ____ Yes _____ No

If Yes, describe: ______________________________

Would your child like your spiritual/religious beliefs incorporated into the counseling? _______ Yes ____ No

If Yes, describe: ______________________________

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 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): ______________________________

Performance in School (Parent's Opinion):

____ 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): ______________

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: ___________________

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
____ Ear aches
____ Ear infections
____ Eczema
____ Encephalitis
____ Fevers
____ Hay-fever
____ Heart trouble
____ Hepatitis
____ Hives
____ Influenza
____ Lead poisoning
____ Measles
____ Meningitis
____ Miscarriage
____ Multiple sclerosis
____ Mumps
____ Muscular Dystrophy
____ Nose bleeds
____ 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: ____

____

Please check if there have been any recent changes in the following:

____ Sleep patterns ____ Eating patterns ____ Behavior ____ Energy level

____ Physical activity level ____ General disposition ____ Weight ____ Nervousness/tension

Describe changes in areas in which you checked above: ______________________________________

____

Most recent examinations	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last vision exam			

Last hearing exam	____	____	____
Most recent surgery	____	____	____
Other surgery	____	____	____
Upcoming surgery	____	____	____

Family history of medical problems: ____

Medications

Current prescribed medications	Dose	Dates	Purpose	Side effects

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

Allergic to any medications or drugs? ____ Yes ____ No

If Yes, describe: ____

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: ____

Chemical Use History

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

If Yes, describe & complete information below: ____

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol								
Barbiturates								
Valium/Librium								
Cocaine/Crack								
Heroin/Opiates								
Marijuana								

PCP/LSD/Mescaline	____	____	____	____	____	____	____	____
Inhalants	____	____	____	____	____	____	____	____
Caffeine	____	____	____	____	____	____	____	____
Nicotine	____	____	____	____	____	____	____	____
Over the counter	____	____	____	____	____	____	____	____
Prescription drugs	____	____	____	____	____	____	____	____
Other drugs	____	____	____	____	____	____	____	____

Substance of preference

1. ____________________ 3. ____________________
2. ____________________ 4. ____________________

Substance Abuse Questions **to be answered by Child/Adolescent**

Describe when and where you typically use substances: ____________________

Describe any changes in your use patterns: ____________________

Describe how your use has affected family or friends (include their perceptions of your use):

Reason(s) for use:

____ Addicted ____ Build confidence ____ Escape ____ Self-medication

____ Socialization ____ Taste ____ Other (specify): ____________

How do you believe your substance use affects your life? ____________________

Who or what has helped you in stopping or limiting your use? ____________________

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

____ Yes ____ No If Yes, describe: ____________________

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ____ Yes ____ No

If Yes, describe: ____________________

Have you had adverse reactions or overdose to drugs or alcohol? (describe):____________

Does your body temperature change when you drink? _______ Yes _______ No

If Yes, describe: ____________________

Have drugs or alcohol created a problem for your job or school? ________ Yes ____ No

If Yes, describe: ____________________

Counseling/Prior Treatment History

*Information about **child/adolescent** (past and present):*

	Yes	No	When	Where	Child/Adolescent's reaction to overall experience
Counseling/Psychiatric treatment	____	____	____	____	____
Suicidal thoughts/attempts	____	____	____	____	____
Drug/alcohol treatment	____	____	____	____	____

	Yes	No	When	Where	Child/Adolescent's reaction to overall experience
Hospitalizations	____	____	____________	__________________	________________
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	____________	__________________	________________

Information about ***family/significant others*** *(past and present):*

	Yes	No	When	Where	Child/Adolescent's reaction to overall experience
Counseling/Psychiatric treatment	____	____	____________	____________________	_____________
Suicidal thoughts/attempts	____	____	____________	__________________	________________
Drug/alcohol treatment	____	____	____________	__________________	________________
Hospitalizations	____	____	____________	__________________	________________
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	____________	__________________	________________

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
____ Drugs 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
____ Over active
____ 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
____ Stomach aches
____ 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 are your child's problematic behaviors 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: ______/_____/______

Supervisor's comments: ____

____

____ Physical exam: _________ Required _____ Not required

Supervisor's signature/credentials: ____________________________________ Date: ______/_____/______

(Certifies case assignment, level of care and need for exam)