

Awareness Counseling

Date of intake: _____ Child/Teen History Form

Parent/Guardian to complete for young children.

Child's Name: _____ Birthdate: _____

Name of adult completing form : _____ Relationship _____

Address: _____

Phone _____ City: _____ State: _____

Zip: _____

A. FAMILY AND DEVELOPMENTAL HISTORY

Current Household:

Mother

Name: _____

Date of Birth: _____

Current Employer: _____

How Long Employed: _____

Occupation: _____

Father

Name: _____

Date of Birth: _____

Current Employer: _____

How Long Employed: _____

Occupation: _____

Step-Parent Name: _____

Date of Birth: _____

Current Employer: _____

How Long Employed: _____

Occupation: _____

Other Adults

Name: _____

Date of Birth: _____

Current Employer: _____

How Long Employed: _____

Occupation: _____

Who has guardianship/custody of the child? _____

Relationship to the child _____

P.2, Intake form continued

Names and ages of brothers and sisters living at home: _____

Names and ages of brothers and sisters living elsewhere: _____

With whom are they living: _____

Who supports this child?: _____

B. LIVING ARRANGEMENT

How many residences has child lived in since birth?

Cities these residences have been located in? _____

Does child share a room with anyone else? No ____ Yes ____

If no, how long has child had own room? _____

If yes, shares room with whom? _____

Was child adopted? No ____ Yes ____ If adopted, at what age? _____

If yes, is child aware they are adopted? No ____ Yes ____

Length of pregnancy: _____ (months)

Was pregnancy easy? _____ Difficult? _____ Was infant premature? No ____

Yes ____ If yes, how many months? _____

Did mother receive any medication during delivery? _____

Did infant receive any medication? No ____ Yes ____ If yes, what kind? _____

Has child had any problems with vomiting, diarrhea, constipation or colic? No ____

Yes ____

Please specify type, how long, and what age: _____

P.3, Intake form continued

Have there been any sleep problems, head banging, thumb sucking, teeth grinding, temper tantrums? No _____ Yes _____

Specify/Describe: _____

When did your child stand alone? _____ Walk? _____

Use words? _____ Speak in sentences? _____

If there were any problems, please describe: _____

When was your child toilet-trained: Bladder - Day _____

Night _____

Bowel _____ Any problems? No _____ Yes _____

Please describe: _____

SCHOOL-AGE:

Did/does your child attend a pre-school/day care program? No _____ Yes _____ If yes, what age? _____

For how long? _____

What is your child's current grade level? K 1 2 3 4 5 6 7

8 9 10 11 12

Recent average grade: A B C D E

Has there been a change in grade average in the past six (6) months? No _____ Yes _____

If yes was change up? _____ Down? _____

Has your child ever been in a Special Education program? No _____ Yes _____ If yes, where? _____ When? _____ How long? _____ What grades? _____

Has your child repeated any school grades? No _____ Yes _____ If so, when? _____ Which grade(s)? _____

Has your child ever been tutored or received special help? _____ If yes, when? _____ What subjects? _____

Has your child ever been suspended from school? No _____ Yes _____ Expelled? No _____

Yes _____ If yes, please explain the

circumstances: _____

P.4 Intake form continued

ADOLESCENCE: If your child is a teenager, what physical changes have you noticed? _____

Have you noticed a change in your child's attitude towards: School _____ Family _____
Friends _____ Recreational Activities _____ Please
describe: _____

Does your child have a paying job? No _____ Yes _____ If yes, where?
How many hours worked per week? _____
Has your child ever discussed future plans with you? No _____ Yes _____ Please describe
them: _____

D. DRINKING HISTORY

Age at time of: First drink _____ First intoxication _____ Recognition of
problem _____ Drink
preference(s): _____
Quantity: _____
Frequency: _____

DRUG HISTORY

List all drugs used: _____

Age at time of first use: _____

First Problem: _____

Quantity: _____

Frequency: _____

Does the child smoke cigarettes? _____ Yes _____ No

Chemical Dependency Treatments - (detox, inpatient, residential)

Diagnosis Facility Date _____

Family use of alcohol, other drugs (include mother, father, siblings)

Relationship _____

Type _____

Quantity _____

Frequency _____

P.5, Intake form continued

Has parental figure ever undergone treatment or received help for an alcohol or drug problem? _____ If so, who? _____

When? _____ From what source was help sought? _____

E. PREVIOUS PSYCHOLOGICAL OR PSYCHIATRIC TREATMENT

Has the child ever been seen for emotional problems? No ____ Yes ____ If yes, by whom and when? _____

Have other family members had emotional problems? No ____ Yes ____ If yes, please describe: _____

Has this child ever lived away from home because of emotional problems or family problems? No ____ Yes ____ If yes, please describe: _____

Has this child ever been in trouble with the court(s) and/or police? No ____ Yes ____ If yes, please describe: _____

F. SOCIAL

How would you describe your child's social network of friends? _____

Is there any spiritual/religious/philosophical tradition(s) or teachings which have had a significant effect on the family? _____

What are your child's strengths and talents? _____

What are your child's favorite leisure activities? _____

P.6, Intake form continued

What brings you to therapy at this time? _____

What do you hope to get out of therapy at this time? _____

Anything else you would like to add? _____

Thank you!