THE CHILD & FAMILY COUNSELING GROUP, P.L.C.
Comprehensive Diagnostic & Therapeutic Services

Child & Adolescent History Form

Form completion date: ___________

Please fill out this form to the best of your knowledge. If some questions are not applicable to you or your child, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.

General Information

Name of person completing this form: ______________________ Relation to patient: ____________

Child's Name: ____

First *Middle* *Last*

D.O.B: _________ Age: __________ Gender: _________________

Home Address: _______________ Phone: _______________

_______________ _______________

School: ______________________ Grade: _______________

Referral Information

How were you referred to CFCG?

____

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Current Concerns

____
____
____
____
____

How long has this problem(s) existed? ___________ Years _____________Months

What have you been told by others regarding your child's difficulties?____
____
____
____

What can we do to help you and your child?
____
____
____
____

Who lives in the home?

Name	Age	Relationship	Education Level	History of Emotional Difficulties

Mother's Information

Name: ________________________________ Occupation: ______________________

Health Status:
____

Mother's Marital History

Dates (FROM-TO)	Spouse's Name	How did marriage end?

Father's Information

Name: ____________________________ Occupation: _________________________

Health Status:
____

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Father's Marital History

Dates (FROM-TO)	Spouse's Name	How did marriage end?

BLENDED, SEPARATED DIVORCED FAMILIES PLEASE COMPLETE THE FOLLOWING

When did the divorce/separation occur?

____

Who is the custodial parent?

____

Where is the non-custodial parent?

____

Mother's Children

Name	D.O.B.	Relationship

If not remarried, does mother have significant other? ☐ ☐ Yes ☐ No

If yes, who? ______________________________ How long married? _______________

Father's Children

Name	D.O.B.	Relationship

If not remarried, does father have significant other? ☐ Yes ☐ No

If yes, who? ___________________________________ How long married? ______________

Developmental and Health History

Was the child from a planned pregnancy? ☐Yes ☐No

Was the child adopted? ☐ Yes ☐ No If yes, how old was the child at time of adoption? _____

Were there any problems during the pregnancy? (I.e. toxemia, diabetes, high blood pressure, etc.)

___

___

___

Were there any problems during the labor or delivery?

___

___

___

Were there any problems during the first 3 months post-delivery? (I.e. feeding, sleeping, breathing problems, other)

___

___

___

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Developmental Milestones

Please list the age at which your child accomplished the following developmental milestones. If you feel the milestone is not appropriate yet for the age of your child, please write N/A.

Milestone	Age
Sat Alone	
Crawled	
Toilet training started	
Toilet training ended	
Stood Alone	
Walked without holding	
Rode Tricycle	

Has the child had any of the following diseases?

Name	Check yes or write N/A	If yes, what age?
Measles		
Mumps		
Chicken Pox		
Strep Throat		
Ear Infections		

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Medication History

Medication Name	Dosage	Directions	Check if presently taking	Start date – End date	Reason for discontinuing

Has the child had any of the following difficulties? If yes, please explain.

	Check yes or write N/A	If yes, please explain
Accidents/Fractures		
High Fever		
Seizures		
Food Poisoning		
Lead Ingestion		
Bedwetting or Soiling		

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	Check yes or write N/A	If yes, please explain
Constipation		
Vision Problems		
Hearing Problems		
Speech Problems		
Speaking Excessively Loud		
Memory Problems		
Allergies		
Aggressive Behavior		
Unusual Fears		
Sleeping Difficulties		
Head Banging		

	Check yes or write N/A	If yes, please explain
Rocking		
Temper Tantrums		
Discipline Problems		
Other		

Adolescent

(12-18 years of age)

(Please check all that apply)	Yes	No	N/A	Additional Information
Have menses begun?				Onset age?
Does he/she date?				
Is he/she sexually active?				
Has she been pregnant				If yes, results of pregnancy?
Does he/she drive?				
Does he/she work?				Where & Hours worked per week?

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Extracurricular Activities

____

____

____

____

____

____

____

____

____

____

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Does he or she have a group of close friends? ☐ Yes ☐ No

How does he/she relate to authority?
____
____
____

Any of the following?

Drugs ☐ Yes ☐ No

Alcohol ☐ Yes ☐ No

Tobacco ☐ Yes ☐ No

Has he/she ever run away? ☐ Yes ☐ No

If yes, when?
____
____

Where did they run away to? ____________________ For how long? ____________________

Has he/she been hospitalized for emotional problems? ☐ Yes ☐ No

Please list all psychiatric hospitalizations evaluations

Type of Evaluation	Date (s)	Hospital/Facility	Treating Doctor

Has he/she ever been suspended/expelled from school? ☐ Yes ☐ No

If yes, when: ___________________________________

Why? ____

Any legal problems? ☐ Yes ☐ No

If yes, what were the circumstances?

____

____

Any suicidal language, gestures, or attempts? ☐ Yes ☐ No

If yes, please describe:

____

Academic History

Name of School	City/State	Grade(s)	Problems (if any)

Has your child been retained? ☐ Yes ☐ No

Has your child been tested? ☐ Yes ☐ No

Please list any previous evaluations (i.e. Psychological, Educations, etc.)

Place of Evaluation	Type	Address	Date

Has your child ever been is a special class placement, received remedial help, or had tutoring?
Yes ☐ No ☐

If yes, please specify

____

____

Relationship with Teachers (please check one)

☐ Excellent

☐ Average

☐ Poor

Relationship with Peers (please check one)

☐ Excellent

☐ Average

☐ Poor

Please bring copies of all Psychological, Educational, or other evaluations to your upcoming appointment.

Activities

What things does your child like to do?

____

____

____

What things does your child do well?

____

____

____

What things present difficulty for your child?

____

____

____

Does your child recognize dangerous situations? ☐ Yes ☐ No

Give detailed description of an average day:

____

____

____

____

____

Other comments:

____

____

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Symptoms Checklist

(please check yes or no)

Symptom	Yes	No
Difficulty falling asleep		
Trouble remaining sleep		
Loss of Appetite		
Excessive Appetite		
Binge Eating		
Excessive Exercising		
Trouble Concentrating		
Trouble Sitting Still		
Feelings of Sadness		
Tearfulness		
Irritability		
Trouble Controlling Aggression		
Trouble Making Friends		
Trouble with the Law		
Ever been arrested		
Uses drugs		
Uses Alcohol		
Smokes Cigarettes		
Runs away from home		
Hears voices		
Sees visions		
Oppositional to authority		
Gets in fights		
Has been sexually abused		
Sexually molested other children		
Takes medication at this time		

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Please elaborate on symptoms marked yes: