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Personal History—Children and Adolescents (<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: _____

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 parents 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 the 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 the 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		
			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
_____	_____	___ 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:

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Deafness | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glandular problems | <input type="checkbox"/> Perceptual motor disorder |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Heart diseases | <input type="checkbox"/> Mental retardation |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Spinal bifida |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Cleft lips | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Multiple sclerosis | _____ |

Comments re: Family Health: _____

Childhood/Adolescent History

Pregnancy/Birth

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

If yes, describe: _____

Was the pregnancy with the 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:

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Breast fed | <input type="checkbox"/> Milk allergies | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bottle fed | <input type="checkbox"/> Rashes | <input type="checkbox"/> Colic | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Not cuddly | <input type="checkbox"/> Cried often | <input type="checkbox"/> Rarely cried | <input type="checkbox"/> Overactive |
| <input type="checkbox"/> Resisted solid food | <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Irritable when awakened | <input type="checkbox"/> 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-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 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 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

- | | | |
|--|---|---|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hives | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Influenza | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Lead poisoning | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Congenital problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Severe colds |
| <input type="checkbox"/> Croup | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Severe head injury |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Sexually transmitted |
| disease | | |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mumps | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Ear aches | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Wearing glasses |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Other skin rashes | <input type="checkbox"/> Other |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Paralysis | _____ |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Pleurisy | |

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: _____			

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	___	___	15 months _____
MMR (Measles, Mumps, Rubella)			
4 months	___	___	24 months _____
HBPV (Hib)			
6 months	___	___	Prior to school _____
HepB			
18 months	___	___	
4-5 years	___	___	

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	_____	_____	_____	_____	_____

Behavioral/Emotional

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

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

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

How are problem 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: _____

Therapist's comments: _____

Therapist's signature/credentials: _____ Date: ___/___/___
_____/_____

_____ Physical exam: Required Not required