Hope for Healthy Families Counseling Center
9075 Elk Grove Blvd, Suite 220A
Elk Grove, California 95624
Phone/Fax (916) 686-9209

CHILD'S PERSONAL HISTORY FORM

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: ___Male___ Female

Address(s):_____

_____

Name of parents/guardian:

_____
(Last) (First) (Middle Initial)

_____
(Last) (First) (Middle Initial)

I, _____, as the responsible parent or legal guardian, hereby authorize counseling to be provided to the above-named minor.

_____ _____
Signature Date

(Please circle preferred contact number.)
Home Phone: _____ May we leave a message? ___Yes ___No
Cell/Other Phone: _____ May we leave a message? ___Yes ___No
Cell/Other Phone: _____ May we leave a message? ___Yes ___No
E-mail: _____ May we email you? ___Yes ___No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):
_____

_____

You have contacted this therapist for services regarding your child. In order to obtain a more comprehensive understanding of your child and your family, please complete this form. Feel free to leave

any question blank, but also consider that more information may allow me the opportunity to tailor the treatment plan to effectively meet your child's needs.

What prompted you to seek services?

_____

_____

How long has this been a problem?

_____

Does your child/children view themselves as having a problem? ____ No ____ Yes If so, how would they describe the problem?

_____

_____

What specific symptoms/problems do you think are relevant? Please check all that apply.

__ Aggressive behaviors
__ Angry outbursts
__ Crying easily
__ Trouble concentrating
__ Fatigue or loss of energy
__ Depressed mood
__ Feelings of worthlessness
__ Odd behaviors or thoughts
__ Difficulty following directions
__ Sleep disturbances
__ Relationship problems
__ Dizziness or lightheadedness
__ Recent weight change
__ Fears/phobias
__ Coping problems
__ Social withdrawal
__ Alcohol/drugs
__ Grief or loss issues
__ Learning problems
__ Thoughts of hurting self /others
__ Recent traumatic events
__ Unresolved childhood issues
__ Oppositional/defiant
__ Illness or medical problems
__ Shyness
__ Chest pains
__ Stomach problems
__ Irritability
__ Sweating
__ Financial stress
__ Academic problems
__ Restlessness
__ Parenting problems
__ Nightmares

In the space below, please feel free to further explain any of the above items.
Has your child or your family experienced any profound losses in the past few years?

_____

_____

SIGNIFICANT RELATIONSHIPS/FAMILY INFORMATION

Tell me about the people in your child's life:	Relationship:	Name/Age:
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

PARENTAL INFORMATION

_____ Parents married/partnered, how long? _____

_____ Parents separated. How long ago? _____

_____ Parents divorced. How long ago? _____
_____ Father remarried: Number of times _____
_____ Mother remarried: Number of times _____

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.)
_____

_____

DEVELOPMENT
Has your child ever been abused? _____ No _____Yes. If yes, which types of abuse? _____ Sexual _____ Physical _____ Verbal. If yes, was the abuse reported? _____ No _____Yes.
Other childhood issues: ___ Neglect ___ Inadequate Nutrition ___ Medical Complications

Any comments regarding developmental experiences:
_____

_____

SOCIAL RELATIONSHIPS
Check how your child generally interact with friends and family members: (check all that apply)
_____ Lovingly _____ Fight/Argue _____ Get picked on _____ Try to avoid them
Other (Please specify) _____

How would you describe his/her personality? (Check all that apply)
_____ Follower _____ Friendly _____ Leader _____ Outgoing _____ Shy/withdrawn
Other (Please specify): _____
Does he/she have a best friend now? _____ No _____ Yes In the past? _____ No _____ Yes
Social strengths: _____

Social stressors/problems: _____

_____

CULTURAL / ETHNIC
To which cultural or ethnic group, if any, do you belong? _____

Cultural and Ethnic strengths: _____

Cultural and Ethnic stressors/problems: _____

SPIRITUAL / RELIGIOUS (Please leave blank if you are uncomfortable answering the following questions)
How important to your family are spiritual matters? ____ Not ___ Little ___ Moderate __ Much
Are you affiliated with a spiritual or religious group? ____No _____Yes (describe)

_____

Spiritual strengths: _____

_____

Spiritual stressors/problems: _____

_____

LEGAL: Has your child ever been arrested? List all charges, dates of arrests, and the outcomes:

_____

_____

Please describe any past or present services or systems that have been involved in your life (e.g., CPS, Government support, school counseling, justice system, etc.

_____

_____

EDUCATIONAL:
What grade is your child in? _____What school do they attend?_____

Academic Grades (check one): □ above average, □ average, □ below average, □□ inconsistent

Does your child receive any special education services or have any special needs with regards to learning?
_____ No _____ Yes (describe) _____

_____

Has he/she ever been retained or held back a grade? _____ No _____Yes Which one(s)? _____

How many schools have they attended? _____ Do they like school? _____ No _____Yes

MEDICAL / PHYSICAL HEALTH
_____ Active Medical Problems ____ Past Hospitalizations
_____ Major Medical Illness ____ Other Medical Problems (describe) _____

If any above items checked, please describe:

_____

_____

Please check if there have been any recent changes in the following:
_____ Sleep patterns _____ Eating patterns _____ Behavior _____ Energy level

_____ General disposition _____ Weight _____ Nervousness_____ Physical activity level
Describe changes marked above: _____

_____

COUNSELING / PRIOR TREATMENT HISTORY
Has your child ever participated in any previous counseling/therapy services? _____ No _____ Yes (describe when/where)

_____

_____

Is he/she currently seeing another therapist? _____ No _____ Yes If so, who? _____

_____

_____

_____

Have any of your family members or significant relationships been involved in counseling or treatment? _____ No _____ Yes (describe)

_____

_____

Has your child (ren) ever been hospitalized for drugs/alcohol/psychiatric care? _____ No _____ Yes (when/where)

_____

_____

_____

Is your child on any psychotropic medications? _____No _____Yes If so, please list:

_____ _____ _____

_____ _____ _____

Has your child (ren) ever attempted suicide or had suicidal thoughts? _____ No _____ Yes (If so describe)
_____

_____

_____

STRENGTHS AND NEEDS

What do you see as your child's and your family's strengths?_____

_____

Is there any other information about you that you think is relevant for your child's treatment planning?
_____

_____

Please list at least one goal you would like to reach during the course of your child's treatment.

_____

_____

_____

_____ _____
NAME OF PERSON COMPLETING THIS FORM DATE

_____
RELATIONSHIP TO THE CLIENT