CHILD/ADOLESCENT Personal History Form
The Grace Counseling Center

Welcome to the Grace Counseling Center! Parents, please be sure that this form is completed prior to your first session so that your counselor can gain a better understanding of your background, concerns and goals for counseling.

Child/Adolescent Name:_____ Date of Birth: _____

Address:_____ City:_____ Zip:_____

Home Phone:_____ Parent Cell Phone: _____

Family History

	Father	Mother
Name:		
Age:		
Highest Grade Level:		
If deceased, dates:		

If the child's parents are not currently married, please describe below (dates of adoption, divorce, remarriage, names of step-parents, and/or other relevant information):

_____

_____

Brothers/Sisters Names	Age	Sex	Grade	Deceased?	Where living?

Are both parents in agreement with bringing him/her for counseling? ____ Yes ___ No

Please describe any recent changes for your family (births, deaths, moves, accidents, etc.):

Treatment Information

Person Completing form: _____Relationship to child:_____

Reason for treatment: _____

_____

Previous Treatment? ___ Yes ___ No If yes, please explain: _____

_____

How does your child/adolescent feel about counseling at this time? _____

_____

In what way would you like counseling to help your child/adolescent? _____

_____

What family members are likely willing to participate in your child's counseling? _____

_____

Developmental and Educational Background

Did your child generally meet developmental milestones (i.e., walking, talking, etc.) on time? _____

Explain any developmental concerns: _____

Current Grade:_____ Name of School: _____

Please describe any difficulties your child/adolescent is having in school: _____

_____

Has your child ever been psychologically tested? _____ When? _____

Religious and Spiritual Background

Does your child/adolescent attend church? _____ Name of church: _____

What role does spirituality play in his/her life? _____

Medical Background and History

Physician: _____ City: _____

Last seen (approximately): _____ for _____

On-going Medical Conditions: _____

Is your child/adolescent taking any prescription medication?

Medication: _____ Treating: _____ Dosage: _____ Since: ____

Medication: _____ Treating: _____ Dosage: _____ Since: ____

Side effects? _____

Has your child had a hearing exam? _____ Eye exam? ____ Any problems discovered? _____

Has your child used drugs or alcohol? ____ Has this use ever caused a problem? _____

Family history of substance abuse? ____ Explain: _____

Please check any areas of concern:

___ Moody	___ Concentration	___ Anxious/worries	___ Can't fall asleep
___ Shy	___ Appetite too low	___ Defiant	___ Can't stay asleep
___ Has been bullied	___ Has bullied others	___ Sad	___ Low energy level
___ Has been abused	___ Has abused others	___ Homicidal or Suicidal thoughts	

Please explain any of the above: _____

Please check areas of relative strength or giftedness:

___ Compassionate	___ Creative	___ Sensitive	___ Sense of Humor
___ Insightful	___ Loving	___ Determined	___ Independent
___ Academics	___ Reading	___ Math	___ Science
___ Athletic	___ Coordinated	___ Reflective	___ Social

Please explain any of the above: _____

Is there anything else that would be good for your counselor to know? ____ (Use back to explain.)

_____

Signature Date