

MEQUON CLINICAL ASSOCIATES, SC

CHILD / ADOLESCENT HISTORY

INSTRUCTIONS: Therapist would like parents / guardian answers to these questions to help better understand your child's situation.

Child's Name: _____ D.O.B. ____/____/____

Counselor's Name: _____

In case of emergency, please give name and phone number of child's parent or legal guardian:

Name: _____ Phone: _____

Child's School: _____ Phone: _____

School Contact (counselor/teacher, etc.): _____ Phone: _____

PSYCHOLOGICAL HISTORY

What problem(s) caused you to come to therapy?

Have there been any recent illnesses or deaths among your family or close friends? Yes No

Have there been any recent crises or major changes for your family? Yes No

Any history of emotional, physical, or sexual abuse in the family? Yes No

Has your child ever intentionally hurt himself/herself or made a suicide attempt? Yes No

Has your child ever intentionally hurt others? Yes No

Has your child ever run away? Yes No

Is your child or any family member taking any medication for anxiety, depression, sleep, or other behavioral health issues? Yes No

Is there a family history of emotional problems? Yes No

Have you or your child ever been in counseling or psychotherapy before? Yes No

If yes, for what issues? _____

Who did you see and when? _____

Any hospitalizations in the family for emotional problems? Yes No

Please name any people or organizations that provide help and support to your family:

MEDICAL HISTORY

List your child's current medical conditions: _____

Are any medications taken for these conditions? Yes No

If yes, what medications and dosages? _____

List other major medical conditions your child had in the past (including surgeries): _____

Name of child's physician(s), telephone number(s) and address(es): _____

When was child's last medical exam? _____

Describe other significant medical conditions in your family, including inherited disease or disabilities:

Check any of these symptoms your child experienced in the past year:

- | | | |
|---|--|--|
| <input type="checkbox"/> School problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Crying spells |
| <input type="checkbox"/> Learning disability | <input type="checkbox"/> Anemia | <input type="checkbox"/> Eating changes/problems |
| <input type="checkbox"/> Developmental delays | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sleep changes/problems |
| <input type="checkbox"/> Speech problems | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Refuses to obey |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Low energy/fatigue | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Short attention span | <input type="checkbox"/> Bedwetting or soiling | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Other _____ | |

DRUG AND ALCOHOL USE

Please describe the drug and alcohol use of your family. Use the number which best states how often each person uses each drug. For siblings, please write in the name of sibling at the top of the column.

0 = Never; 1 = less than once a month; 2 = 1-4 days a month; 3 = almost daily; 4 = daily; 5 = used in past, not using now

SUBSTANCE	CHILD	MOTHER	FATHER	SIBLING
Nicotine	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
LSD	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____
Other	_____	_____	_____	_____

LEGAL PROBLEMS

- Has your child ever had problems with law enforcement?** Yes No
- Has your child ever been involved with Protective Services?** Yes No

SCHOOL HISTORY

- Where does your child currently enrolled in school?** _____
- Does your child have a problem with school attendance?** Yes No
- Does your child have a problem with school behavior?** Yes No
- Does your child have a problem with learning or academic performance?** Yes No
- Child's highest grade completed:** _____