BiofeedbackWORKS In Virginia PLLC

PERSONAL HISTORY—CHILDREN AND ADOLESCENTS

Client's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: ____ Grade in school: _____

Form completed by (if someone other than client): _____

(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 ___ Anxiety ___ Inattention ___ Depression

___ Eating disorder ___ Fear/phobias ___ Mental confusion ___ Sexual concerns

___ Sleep problems ___ Addictive behaviors ___ Alcohol/drugs ___ Hyperactivity

___ Other concerns (please specify): _____

_____

Medical/Physical Health

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

Does your child consume any of the following? If so, in what quantities?

Cigarettes _____ Cigars _____Other Tobacco Products _____

Comments: _____

Current prescribed medications:	Dose	Dates	Purpose	Side effects

Current over-the-counter meds:	Dose	Dates	Purpose	Side effects

Family History

Parents

With whom does the child live at this time? _____

Are parents divorced or separated? _____ If Yes, who has legal custody? _____

Is there any significant information about the parents' relationship or treatment toward the child which might be important for us to know? _____Yes _____ No If Yes, describe: _____

Is the child adopted? ___ Yes ___ No

Client's Mother

Name: _____ Age: _____ Occupation: _____

Describe how your child gets along with his mother: _____

_____

How is the child disciplined by the mother? _____

For what reasons is the child disciplined by the mother? _____

Client's Father

Name: _____ Age: _____ Occupation: _____

Describe how your child gets along with his father: _____

_____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

Client's Siblings

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
_____	_____	___ 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 in the household with the client:

Names	Age	Gender	Lives	Quality of relationship with the client
_____	_____	___ 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

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:

___ Asperger's	____ Deafness	____ Nervousness
___ Autism	____ Drug addiction	____ Mental Retardation
___ AD/HD	____Depression	____ Seizures
___ Alcoholism	____ Mental illness	____ Suicide
___ Blindness	____ Migraines	___ Other (specify): _____

Comments concerning 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 child planned? ___ Yes ___ No Length of pregnancy: _____

Mother's age at child's birth:_____ Father's age at child's birth:_____

Child is number _____of _____ total children.

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 Forceps?___ 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: _____

_____

_____

Infancy/Toddlerhood

Check all which apply:

___ Breast fed	____ Milk allergies	____Vomiting	____ Diarrhea
___ Bottle fed	___ Rashes	____ Colic	___ Constipation
___ Not cuddly	___ Cried often	____ Rarely cried	____ Overactive
___ Resisted solid food	____ Trouble sleeping	___ Irritable when awakened	____ Lethargic

Developmental History

Please note the age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____

Took 1st steps: _____ Spoke words: _____

Spoke sentences: Dry during day: _____

Dry during night: _____

Compared with others in the family, child's development was: ___ slow ___ average ___ fast

Issues that affected child's development (e.g. injuries, hospitalization, 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 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?

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

	Yes	No	When	Where	Reaction to 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:

___ Affectionate
___ Aggressive
___ Alcohol problems
___ Angry
___ Anxiety
___ Attachment to dolls
___ Avoids adults
___ Bedwetting
___ Frustrated easily
___ Gambling
___ Generous
___ Hallucinations
___ Head banging
___ Head injury
___ Hopelessness
___ Hurts animals
___ Sad
___ Selfish
___ Separation anxiety
___ Sets fires
___ Sexual addiction
___ Sexual acting out
___ Shares
___ Sick often

___ Blinking, jerking
___ Bizarre behavior
___ Bullies, threatens
___ Careless, reckless
___ Chest pains
___ Clumsy
___ Confident
___ Cooperative
___ Cyber addiction
___ Defiant
___ Depression
___ Destructive
___ Difficulty speaking
___ Dizziness
___ Drugs dependence/overdose
___ Eating disorder
___ Enthusiastic
___ Excessive masturbation
___ Expects failure
___ Fatigue
___ Fearful
___ Frequent injuries
___ Imaginary friends
___ Impulsive
___ Irritable
___ Lazy
___ Learning problems
___ Lies frequently
___ Listens to reason
___ Loner
___ Low self-esteem
___ Moody
___ Nail-biting
___ Nightmares
___ Obedient
___ Often sick
___ Oppositional
___ Over active
___ Overweight
___ Panic attacks
___ Phobias
___ Poor appetite
___ Psychiatric problems
___ Quarrels
___ Short attention span
___ Shy, timid
___ Sleeping problems
___ Slow moving
___ Soiling
___ Speech problems
___ Steals
___ Stomach aches
___ Suicidal threats
___ Suicidal attempts
___ Talks back
___ Teeth grinding
___ Thumb sucking
___ Tics or twitching
___ Unsafe behaviors
___ Unusual thinking
___ Weight loss
___ Withdrawn
___ Worries excessively
___ Other: (please list)
_____
_____

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

If Yes, at what age? _____ 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: _____

_____

-For Staff Use-

Therapist's comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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