ST JOHN HEALTH EASTWOOD CLINICS

# CHILD/ADOLESCENT PERSONAL HISTORY
## (Ages 17 & Under)

**Case #:** _____

**TO BE FILLED OUT BY THE PARENT OR GUARDIAN. THE INFORMATION THAT YOU PROVIDE TO US WILL BE VERY HELPFUL IN TREATING YOUR CHILD. PLEASE FILL OUT COMPLETELY. IF YOU HAVE DIFFICULTY WITH ANY OF THE QUESTIONS, YOUR CHILD'S THERAPIST WILL REVIEW THEM WITH YOU. THANK YOU!**

**CHILD'S NAME:** _____ **AGE:** _____ **DATE:** _____

Person completing form for Client _____ Relationship to Client: _____

| | FULL NAME | AGE | LIVING IN THE HOME? | IF DECEASED, YEAR & CAUSE |
|---|---|---|---|---|
| **CHILD'S MOTHER** | | | | |
| **CHILD'S FATHER** | | | | |
| **STEP MOTHER** | | | | |
| **STEP FATHER** | | | | |
| **BROTHERS & SISTERS** | | | | |
| | | | | |
| **(Included Step & Half)** | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Who else lives with you other than the ones checked above?** | | | | |

Child was raised by? _____

**Problem:** Describe the problems that child is having (behaviors, feelings, attitudes, school performance, etc.)):

_____

_____

_____

_____

What is the main problem that you are bringing child for? _____

How long has he/she been having these problems? _____

Why do you think child is having these problems? _____

Whose idea was it to have child brought to this clinic for help? _____

What would you or they like to see done for child? _____

Describe how child's problems affect you, other family members and others: _____

_____

## SYMPTOMS: Circle the numbers of all items that you believe fit this child:

1. Speech difficulties
2. Nervous habits/behavior
3. Frequent headaches
4. Frequent stomach-aches
5. Sleep disturbance
6. Difficulty making friends
7. Difficulty keeping friends
8. Little interest in friends
9. Little interest in activities
10. Disrespectful/argumentative
11. Temper tantrums
12. Ignores rules/chores
13. Defies authority
14. Threatening behavior
15. Throws/breaks things
16. Gets in frequent fights
17. Hurts animals
18. Sets fires
19. Steals
20. Lacks guilt/remorse
21. Lies a lot
22. Breaks curfew often
23. Runs away
24. Skips school
25. Doesn't complete schoolwork
26. Has problematic friends
27. Underactive
28. Overactive
29. Acts before thinking
30. Short attention-span
31. Unable to sit still
32. Clowns a lot
33. Accident-prone
34. Sucks thumb
35. Wets the bed
36. Wets/soils clothes
37. Bangs head
38. Grinds teeth
39. Separation problems
40. Worries a lot
41. Afraid/fearful
42. Seems insecure
43. Withdrawn
44. Shy
45. Sad/depressed
46. Cries frequently
47. Won't sleep in own bed
48. Seems too serious
49. Secretive
50. Looks "high" often
51. Keeps to him/herself
52. Avoids family activities
53. In his/her own world
54. Imaginary friends
55. Unusual behavior
56. Mentally slow
57. Nightmares
58. Acts spoiled
59. Too interested in sex
60. Disorganized/messy

**Please explain each item that you circled** (You may also write on the back of this page):

_____

_____

_____

_____

_____

**Has child ever expressed a wish that he or she were dead? ____ How recently?** _____

**Has child ever threatened or attempted to seriously harm self or others?** _____

**Please explain:** _____

**INTERESTS/ACTIVITIES** (Check all that apply to child):

| | | | | |
|---|---|---|---|---|
| ____ Watch television | _____ Play sports | _____ Paint | _____ Skate | ____ Baby-sit |
| ____ Movies/videos | _____ Ride Bicycle | _____ Draw | _____ Write | ____ Imaginary Play |
| ____ Play video games | _____ Rollerblade | _____ Read | _____ Scouting | ____ Action Figures |
| ____ Listen to music | _____ Build things | _____ Sing | _____ School | ____ Dolls |
| ____ Talk on the phone | _____ Collect things | _____ Dance | _____ Crafts | ____ Sew/knit |

Other interests/activities: _____

Has child lost interest in activities that he/she normally enjoyed? _____

**EMPLOYMENT:** Where does child work? _____ hours per week? _____

Employment/training/work hours of each parent or guardian:

You: _____

Your spouse/partner: _____

**LEGAL HISTORY:** (Describe any legal problems that child has had in past or present):

_____

**EDUCATION:** Name of school: _____ Grade: _____

School Address: _____ Phone: _____

Teacher: _____ Counselor: _____

Is child in any Special classes? _____ Since what grade? _____

Does child hav any Learning Disabilities? _____

Has child repeated any grades? _____ Which ones? _____

Describe child's attendance: _____

Describe effort/attitude toward school: _____

Describe child's *behavior* in school: _____

Describe academic performance: _____

When did school behavior or academic performance change? _____

Education of each parent or guardian: _____

_____

**ETHNIC/CULTURAL BACKGROUND (Child's):** _____

**RELIGIOUS/SPIRTITUAL BACKGROUND (Child's):** _____

## SEXUAL/GENDER ISSUES (Describe any sexual or gender concerns you have about child):

_____

## PREVIOUS MENTAL HEALTH OR ALCOHOL/SUBSTANCE ABUSE TREATMENT:

**OUTPATIENT:** Has the child seen a therapist or counselor for personal or family problems or alcohol/drug treatment?_____

When, where? _____

Reason: _____

**INPATIENT:** Has the child been in a hospital or Residential treatment for personal problems or alcohol/drug problems? _____

When, where? _____

Reason: _____

Were any of the child's treatment experiences helpful? _____

What medications was child prescribed for emotional or behavioral problems? _____

Which of those medications were helpful? _____

List any of child's relatives (parents, grandparents, aunts, uncles, cousins, brothers, sisters) who have been hospitalized for personal or substance abuse problems:

Who, when, where? _____

_____

_____

## PHYSICAL HEALTH: Child's Physician: _____

Physician's Address: _____ Phone: _____

Date child last saw Physician: _____ Reason: _____

Results of Physician visit/tests: _____

Medications child is on: _____

Immunizations up to date? _____

Child's Height: _____ Weight: _____ Appetite: _____ Recent weight gain? _____ Loss? _____

Does child over-eat? _____ Binge? _____ Purge? _____ Energy/activity level: _____

Food or medication allergies: _____

If child has had any serious illnesses, injuries, surgeries or medical hospitalizations, please explain:

_____

_____

**DEVELOPMENTAL HISTORY:** Was your pregnancy desired? _____ Length of term: _____

Problems/complications during pregnancy: _____

Did mother smoke, drink, use drugs during pregnancy? _____

Problems/complications during delivery: _____

Explain if mother and child were separated after birth: _____

Other mother/child separations: _____

Describe child as an infant/toddler (happy, fussy, overactive, withdrawn, etc.): _____

Age child sat up: _____ Took steps: _____ Spoke words: _____ Spoke in sentences: _____

Age child was weaned: _____ Began feeding self: _____

Age that child was toilet-trained during the day: _____ During the night _____ Problem now: _____

Age that child dressed self: _____ Age child tied own shoe-laces: _____

Age that child rod a 2-wheel bike: _____

**FAMILY RELATIONSHIPS:** How do you get along with child? _____

How does spouse/partner get along with child? _____

If one or both of child's parents are out of the home, describe each one's current relationship with child: _____

Father: _____ Mother: _____

How does child get along with brothers & sisters? _____

## RULES/RESPONSIBILITIES/RELATIONSHIPS:

How does child deal with rules, responsibilities, chores? _____

Does child obey curfew? _____ Has child threatened/attempted to run away or stay out all night? _____

How do you deal with child's misbehavior? _____

Do you or your spouse/partner believe in physical discipline? _____

Has the family ever been involved with Protective Services? _____

Are there any situations at home that might have an effect on child's behavior? _____

_____

**Drinking/drug usage: If child *drinks* or *uses drugs*, please also complete the next page.**

| TYPE OF DRUG | AGE OF 1ST USE | AT WHAT AGES WAS CHILD USING IT REGULARLY? | AVERAGE NUMBER OF DAYS USED EACH WEEK | USUAL AMOUNT USED ON AN AVERAGE DAY | NUMBER OF DAYS USED IN PAST 30 DAYS | AMOUNT USED IN THE LAST 48 HOURS | DATE YOU LAST USED |
|---|---|---|---|---|---|---|---|
| Coffee, Cola<br>Caffeine pills | | | | | | | |
| Cigarettes | | | | | | | |
| Beer, Wine | | | | | | | |
| Liquor | | | | | | | |
| Marijuana | | | | | | | |
| Crack Cocaine | | | | | | | |
| Cocaine powder | | | | | | | |
| Heroin: Snort | | | | | | | |
| Heroin: Shoot (IV) | | | | | | | |
| Methadone | | | | | | | |
| Pain Pills:<br>Type: | | | | | | | |
| Codeine; Tylenol 3, 4<br>Other: | | | | | | | |
| Muscle relaxers:<br>Soma, Flexeril<br>Other: | | | | | | | |
| Tranquilizer:<br>Valium, Librium<br>Other: | | | | | | | |
| Glue<br>Poppers<br>Aerosols | | | | | | | |
| PCP, LSD<br>Mescaline | | | | | | | |
| Meth-amphetamine<br>Speed, Ritalin | | | | | | | |
| Phenobarbital<br>Sleeping pills | | | | | | | |
| Steroids | | | | | | | |
| Other: | | | | | | | |
| Other: | | | | | | | |

**What are your drugs of preference: 1. 2.**

**Therapist/Credentials:**_____ **Date:** _____

**Consultant/Psychiatrist Signature:** _____ **Date:** _____