FREMOUW SIGLEY & BAKER PSYCHOLOGICAL ASSOCIATES PLLC
Child/Adolescent Personal History Form (Age 0-17)

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CLIENT INFORMATION

Name: _____ Date: _____ Client Phone: _____
Birth Date: ___/___/____ Address: _____
City: _____ State: _____ Zip: _____
Parent(s) Name(s): _____
Parent Number(s):_____
Emergency contact: _____ Relationship to child: _____
Check (x) legal custodian of child: Parent_____ DHHR____ Other (please specify): _____
Joint Custody: Bring a copy of the divorce-parenting plan prior to the start of the services.
Both parents must consent to non-emergency psychological care. Have both parents completed forms? Yes ☐ No ☐
Why has the child come to treatment? (Include signs and symptoms with duration and severity): _____
_____
What goals would your child like to work on in therapy? _____
How does the child feel about being at FSBPA? _____
☐ We have received an informed consent form and were given the opportunity to ask questions.

CONTACT INFORMATION AND PERMISSION

Email: _____
I authorize: (Please indicate YES or NO for each option)
YES ◯ NO ◯ Leaving a message on my home answering machine
YES ◯ NO ◯ Leaving a message on my work voicemail
YES ◯ NO ◯ Leaving a message on my cell voicemail
YES ◯ NO ◯ Leaving a message with a family member/friend at my home
Only the following: _____
YES ◯ NO ◯ Contact me by mail at the following address (to include billing): _____

HEALTH INSURANCE INFORMATION

Primary Care Physician Name: _____
Name of Policy Holder: _____Birth Date of Policy Holder: _____
Address of Policy Holder: _____
Sex: M☐ F☐ Relationship to Policy Holder: Self__ Spouse__ Child __Other _____
Insurance Company Name: _____
Insurance Mailing Address: _____
ID Number: _____ Group Number: _____ Ins. Co. Phone: _____
Employer: _____ Ins. Phone Number for Mental Health: _____
Is there another health benefit plan? Yes ☐ No ☐
Name of Other Insured: _____ Date of Birth: _____
Other Insurance Company Name: _____

FAMILY BRANCH

	Name	**Age**	**Employer/School**	**Marital Status**
Mother				
Father				
Step-Mother				
Step-Father				
Sibling				
Sibling				
Sibling				
Sibling				

Any family member involved in the military: _____ Who: _____ Branch: _____

EDUCATION

School Name: _____

Has the child ever been afraid/reluctant to go to school? Yes ☐ No ☐ Please explain: _____

_____

Present grade: _____ Repeated grade: Yes ☐ No ☐ What grade(s)? _____

Has the child ever had any difficulties with: Math ☐ Reading ☐ Language ☐ Speech ☐

Has the child had any special education services? Yes ☐ No ☐ What type: _____

Has the child ever received any complaints from their school regarding behavior or achievement? Yes ☐ No ☐

If Yes, explain: _____

How does your child relate to peers? (Please be as specific as possible): _____

_____

Current grades in main subjects: _____

SOCIAL/LEASURE INFORMATION

Social time is usually spent: Alone ☐ Immediate Family ☐ Peers ☐

Describe (interests, hobbies, etc.): _____

How many hours per day does your child spend on social media: _____

Does your child have a job? Yes ☐ No ☐ Hours: _____

Does the family have financial difficulties? Describe: _____

Other family issues: _____

PERSONAL ADJUSTMENT

How does the child relate to:

Mother: _____

Father: _____

A step-parent: _____

Their siblings: _____

Authority figures: _____

ADJUSTMENT DIFFICULTIES

Please check all that apply:

☐ Feels lonely	☐ Does not share	☐ Feelings of guilt	☐ Takes unneeded risks	☐ Unusual behaviors
☐ Shy with children	☐ Lacks motivation	☐ Defiant	☐ Short attention span	☐ Destructive
☐ Shy with adults	☐ Sexually acting out	☐ Stealing from home	☐ Daydreams	☐ Not always truthful
☐ Prefers to be alone	☐ Preoccupied with sex	☐ Stealing from peers	☐ Jealousness	☐ Violent behavior
☐ Worries	☐ Tics or twitches	☐ Will not admit blame	☐ Overactive	☐ Fails to understand consequences
☐ Compulsive behavior	☐ Sets fires	☐ Bedwetting – present	☐ Anxiety/panic	☐ Avoiding people/places
☐ Sad	☐ Ritualistic behavior	☐ Poorly organized	☐ Bedwetting – past	☐ Seeing/hearing things
☐ Cries easily	☐ Impulsivity	☐ Clumsy	☐ Soiling self	☐ Aggressive with peers
☐ Expresses failure	☐ Nightmares	☐ Depression	☐ Unusual thinking	☐ Aggressive with siblings
☐ Anger problems	☐ Appetite changes	☐ Sleep changes	☐ Mood swings	☐ Aggressive with adults

What are the client's strengths? Please check all that apply:

☐ Bright	☐ Insightful	☐ Can accept love/care from others	☐ Compliant to commands	☐ Willing to learn new attitudes and behavior
☐ Has self-control	☐ Have friends	☐ Can calm self	☐ Mostly healthy	☐ Active
☐ Can forgive	☐ Keep boundaries	☐ Have moral ethics	☐ Can solve problems	☐ Accepts responsibility
☐ Can ask for help	☐ Can express feelings	☐ Good listener	☐ Resourceful	☐ Shares well
☐ Sense of humor	☐ Compassionate	☐ Patient	☐ Motivated	☐ Shows empathy

RELIGIOUS/SPIRITUAL ACTIVITIES

Mother's Background: _____ Father's Background: _____
Does the family practice a religion or spirituality? Describe: _____

CULTURAL/ETHNIC BACKGROUND

African-American ☐ Caucasian ☐ Native-American ☐ Hispanic ☐ Other _____
Would you like the therapist to cover any racial/cultural issues? Yes ☐ No ☐ Explain: _____

SEXUAL IDENTITY/AFFECTIONAL ORIENTATION

What is your child's assigned gender at birth? _____ How do they categorize their gender? _____
What does your child identify as their affectional orientation? (LGBTQ+): _____
Preferred pronouns: _____

LEGAL INFORMATION

Is the child currently facing any pending charges or convictions? Yes ☐ No ☐
If yes, explain: _____
Has the child ever been or currently is on probation? Yes ☐ No ☐
If yes explain: _____
Has the child ever been arrested or spent time in a corrections facility? Yes ☐ No ☐
If yes, please explain: _____
Is the child adopted? Yes ☐ No ☐ Have they ever been told? Yes ☐ No ☐ If so, when? _____

TRAUMA HISTORY

Has your child experienced physical abuse? Yes ☐ No ☐
Has your child experienced sexual abuse? Yes ☐ No ☐
Has your child experienced emotional abuse? Yes ☐ No ☐
If yes, explain: _____
_____
Was it reported to authorities? Explain: _____
Has your child experienced other traumas such as involvement in car accidents, fires, floods, the victim of a crime?
Yes ☐ No ☐ If yes, explain: _____

HEALTH HISTORY

Is your child experiencing any physical pain at this time? Yes ☐ No ☐
If yes, explain (location, severity, date of onset, treatment): _____
_____
Are the child's immunizations up to date? Yes ☐ No ☐ Has the child had an eye exam? Yes ☐ No ☐
Has the child had a hearing exam? Yes ☐ No ☐ Has the child begun menstruation? Yes ☐ No ☐ N/A ☐
Glasses? Yes ☐ No ☐ Hearing deficiency? Yes ☐ No ☐
Date of last physical exam: _____ Results: _____
What is the present health of the child (asthma, headache, etc.)? Please describe: _____
_____
Past health problems: Hospitalization, diseases, accidents, abortions, head injuries, or disabilities: _____
_____
Any emotional disorders in extended family? Yes ☐ No ☐ If yes, explain: _____
_____
Any drug or alcohol use in extended family? Yes ☐ No ☐ If yes, explain: _____
_____
Any involvement with alcohol or illicit drugs by the child/adolescent? Yes ☐ No ☐ If yes, explain: _____
_____
Is your child allergic to any medications or drugs? Yes ☐ No ☐ If yes, explain: _____
_____
Other allergies: _____
Family history of medical problems? Explain: _____

List all medications the child is now taking. Also, please list all supplements, herbal remedies, and over-the-counter medications.

Name of medication Dosage Frequency Reasons for Using Prescribed by

_____

_____

Has your child gained weight or lost weight in the last 30-60 days? Yes ☐ No ☐ If yes, explain: _____

_____

BIRTH AND DEVELOPMENT

Pregnancy: Normal? Yes ☐ No ☐ Complications? Explain: _____

Length of labor: _____ Premature? Yes ☐ No ☐ Birth Weight: _____

Newborn's health: _____

INFANCY

Please check all that apply:

☐ Colic	☐ Overactive	☐ Constipation
☐ Eating issues	☐ Underactive	☐ Chronic illness
☐ Sleeping issues	☐ Infections	☐ High fever
☐ Milk or food allergies	☐ Fussy	☐ Hospitalizations
☐ Sleep pattern issues	☐ Cried often	☐ Surgery Other:

EARLY CHILDHOOD DEVELOPMENT MILESTONES

Talking: Single words at: _____ months; Sentences at _____ Months; Walking at _____ months

Began toilet training at: _____ months; Completed toilet training at _____

COUNSELING/PRIOR TREATMENT HISTORY

Has your child ever spoken about or is CURRENTLY experiencing any of the following: Mark all that apply.

Suicidal comments: ☐ Homicidal comments: ☐ Physical violence: ☐ Drug/Alcohol abuse: ☐

Self injurious behavior: ☐ Runaway: ☐

Explain: _____

Has your child had psychotherapy/counseling before? Yes: ☐ No: ☐ If yes, indicate inpatient or outpatient and name of facility/physician/therapist: _____

Length of stay if hospitalized: _____ Number of admissions: _____

Identify when child was in treatment and for what reason(s): _____

_____

Why did treatment stop: _____

Any other information you would like to add: _____

_____

PLEASE REVIEW THIS FORM AND ENSURE THAT YOU HAVE COMPLETED ALL QUESTIONS OR MARKED N/A IF NOT APPLICABLE. I ATTEST THAT I HAVE DISCUSSED ANY QUESTIONS WITH THE THERAPIST REGARDING THIS FORM.

_____ _____

Client signature (if 14 or older) Date

_____ _____ _____

Signature of Informant Print informant's name Date