Peninsula Pastoral Counseling Center

PERSONAL HISTORY FORM:

Children and Adolescents

Introduction:

Thanks for your cooperation with this questionnaire. It's a way for your counselor to get to know you better, so that your counseling here may be more useful for you. The time that you take now with these questions frees up the time that you have with your counselor, so that you can discuss what's the most important.

There are a lot of questions. They are intended to determine the particular help that our clients need. Although some of these questions may not apply to you at all, we trust that many of them do. We appreciate your patience with any questions that aren't very relevant for you. If you need more space, we've set aside page 7 for that purpose. If that's not enough, ask the receptionist to provide more paper.

Your answers to this questionnaire are just as confidential as your counseling is. The "Consent to Treatment" form and the "HIPAA" privacy information describe the extent and the limits of confidentiality.

If you want to discuss your answers with your therapist, please say so. *Of course, you may decline to answer any questions on this form and discuss the matter in person with your therapist instead.*

<u>Clarification for adults who fill out this form on behalf of the young person who is the client</u>: This form is to be filled out from the point of view of the client. So, "you," "your," etc. refers to the client "Father," "mother," etc. refers to the client's parents, etc.. If you don't know the answer to a question, you may leave it blank and the therapist can clarify during the session. Ideally, the young person participates in filling out this form.

If you have any questions about this form or anything else regarding your counseling here, please ask your counselor.

Basic Facts

Name of client____ Date ______________________________

Sex _______ Date of Birth ________________ Social Security Number ____________________________________

Street Address/City/ZIP ____

Phone (Home) ___________________________ Emergency Contact (person) _____________________________
(Work) ____________________________ (phone) _____________________________
(Cell phone) ________________________

Life Status

____ Asian-American
____ African-American
____ Caucasian-American
_____Native American
_____Hispanic American
_____Other _______________________

Your Nuclear Family

Father
Name _________________________ Birth date _____

Employer _____________________________________

Address: _____________________________________

____

Home phone __________________________________

Work phone __________________________________

Cell phone __________________________________

Father's social security # _______________________

If deceased, date and cause of death:

____

Mother
Name _________________________Birth date ______

Employer _____________________________________

Address: _____________________________________

____

Home phone __________________________________

Work phone __________________________________

Cell phone __________________________________

Mother's social security # _______________________

If deceased, date and cause of death:

____

Stepparents (name, birth year, relationship, occupation) ____

____

Siblings/Stepsiblings (name, birth year, relationship) ____

____

____

Please list any other family members or other people living in your home:

Name	Birthday/Age	Relationship	Grade/Occupation

Educational History

Education (highest level completed and date) ____

School currently attending____

Grade____ Teacher____

Extracurricular Activities____

Comments:____

Spiritual/Religious

Current church you're attending, if any____

Comments:____

Medical History

Medical history may be important for understanding and treating emotional issues and relationship problems. Please describe any significant health issues, injuries, etc. for yourself and your family. If needed, use the space on page 7 or ask the receptionist for extra pages if needed.

(Please list medications/herbs that you currently are taking on the "Medication" form)

Do you currently have any physical problems? No ____ Yes (specify) ______________________________________

____

____

Do you have a primary care practitioner? No ____ Yes (name, address, phone) _____________________________

____

For each of the following, please indicate your present and past use.

Tobacco

Ever used? Yes No (circle one) If never used, skip to next question.

Type____

Dates of use____

Amount of use____

Impact on your life.____

Alcohol

Ever used? Yes No (circle one) If never used, skip to next question.

Dates of use____

Amount of use____

Impact on your life.____

For each of the following, please indicate your present and past use. (continued)

Prescription medications

Ever used? Yes No (circle one)

If yes, please list on the last page, “Medication”.

If never used, skip to next question.

Impact on your life.____

Used beyond what was prescribed? Yes No (circle one)

Over the counter medications/herbal products/etc.

Ever used? Yes No (circle one) If never used, skip to next question.

Type ____

Dates of use____

Amount of use____

Impact on your life.____

Used beyond what was recommended? Yes No (circle one)

For each of the following, please indicate your present and past use. (continued)

Illegal drugs

Ever used? Yes No (circle one) If never used, skip to next question.

Type ____

Dates of use____

Amount of use____

Impact on your life.____

Therapeutic Background

Are you currently in treatment with a psychiatrist, psychologist, or other mental health professional? No ___ Yes__

If yes, please list the name of the therapist ____

Have you had previous therapy? No ____ Yes (name of therapist(s), date(s), and outcomes) ___________________

____

____

Have you been hospitalized for psychiatric treatment? No ____ Yes (specify hospital(s), date(s), and outcomes)

____

Do you have any suicidal or homicidal thoughts at the present time? No ____ Yes ____

If yes, do you have any suicidal or homicidal plans? No ____ Yes ____

If yes, do you intend to carry out your plans? No ____ Yes ____

Currently, is somebody harming you physically, emotionally, sexually, or otherwise? Yes No (circle one)

Do you currently fear that somebody will harm you in these ways? Yes No (circle one)

Have you been harmed in these ways in the past? Yes No (circle one)

Present Concerns

Briefly note the concerns that bring you to therapy and the results that you hope to achieve ____________________

____

____

____

____

____

How have you tended to deal with similar problems in the past?____

____

What personal strengths do you have in dealing with the problems that bring you here?

____

____

What contributions from other people in your life (family, work, social, religious, etc.) make it easier for you to cope with these problems?

____

____

What problems with other people in your life (family, work, social, religious, etc.) make it harder for you to cope with these problems?

____

How long do you think it will take you to resolve these problems?

____

____

Referral:

How did you hear about us? ____

If you were sent by a professional, may we thank that person? Please initial ______yes ________no

If yes, please give name, address, or phone number ____

What Else Do You Want to Tell Us?

(If you didn't have room to answer some questions, use this space. If you need more paper, ask the receptionist.)

Signature of person filling out this form ___________________________________ **Date** _________________

Relationship to client ____