The Northwest Catholic Counseling Center

Providing help, creating hope…

Child/Adolescent Psychosocial History

Date_____ Client ID_____
(office use only)

Please provide the following information for your child/adolescent. It will be held to the same standards of confidentiality as the therapy itself.

Child/Adolescent Name_____
First Middle Last

Address_____

_____
City State Zip

Birth date _____/_____/_____

Gender: ☐Female ☐Male ☐Transgender ☐Gender Neutral

Does your child/adolescent identify as LGBTQ? ☐Yes ☐No

Person completing this form_____

Relationship to child/adolescent_____

Mother's Name_____

Best phone # to reach you (c) (h) _____
May we leave a message? ☐Yes ☐No

Father's Name_____

Best phone # to reach you (c) (h) _____
May we leave a message? ☐Yes ☐No

For appointment reminders we can text, email or call. Who should be notified for appointments and how do you want notification:

Who:_____ How:_____

Ethnic identification of your child/adolescent:
☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐Hispanic or Latino ☐Multi-ethnic ☐Native Hawaiian or Pacific Islander ☐White

Office use only:
☐Entered in FM ☐Entered in TH

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www.nwcounseling.org

Over please ↓

Legal Information

Who has custodial guardianship: _____
(You may be asked to provide copy of custodial guardianship)

Stepparent (if applicable)_____

Are you, as the parent or stepparent, involved in any legal proceedings such as divorce, custody disputes, etc? ☐Yes ☐No

If yes, please explain_____

Has your child been involved in the legal system? ☐Yes ☐No

If yes, please explain_____

_____

Medical, Psychological and Developmental History

List any pregnancy or delivery complications or problems._____

_____

Describe any significant medical/developmental history for your child/adolescent including hospitalizations (medical or psychiatric), significant losses, and gaps in living with attachment figures.

_____

_____

Has your child/adolescent experienced any traumatic events? _____

_____

Has your child/adolescent ever attempted or expressed the desire to commit suicide?

Explain: _____

_____

Has your child had any previous counseling? ☐Yes ☐No

If yes, with whom and when?_____

Do you have any concerns regarding your child/adolescent use of alcohol/drugs?_____

_____

Does your child/adolescent have a disability defined as substantially limiting movement, sensory, social, employment, or learning activities. ☐No ☐Yes Is it documented? ☐No ☐Yes

Name of pediatrician._____

When was the last time your child/adolescent saw his/her pediatrician?_____

Does your child/adolescent take any medications? ☐Yes ☐No

If yes, please list all medications and dosages.

Meds	Dosage
_____	_____
_____	_____

List any allergies: _____

Has anyone in your family (either immediate family or relative) experienced difficulties with the following? Check any that apply and list family member (sibling, parent, uncle, etc).

☐	Depression	_____
☐	Anxiety	_____
☐	Schizophrenia	_____
☐	Eating Disorder	_____
☐	Trauma	_____
☐	Bipolar	_____
☐	Panic Attacks	_____
☐	Alcohol/Substance Abuse	_____
☐	Suicide Attempts	_____

Social/Educational Information

Please list names and ages of other children living in the home.

Name	Age
_____	_____
_____	_____
_____	_____

Please describe your child/adolescent interaction with other family members._____

_____

Are there any family stressors (financial, marital, peers, etc) that might be affecting your child?
☐Yes ☐No

If yes, please explain._____

School:_____ Grade:_____

Please describe your child/adolescent's academic performance._____

_____

Please describe your child/adolescent's social interaction at school. _____

_____

List hobbies, sports, music, TV shows, toy preferences, etc._____

_____

How is discipline generally handled in the home?_____

_____

Describe your child/adolescent strengths._____

_____

Concerns and Symptoms

What are your specific concerns for your child/adolescent that have brought you to counseling?

_____

_____

_____

What are your goals for your child/adolescent's therapy?_____

_____

Is there any other information that you believe would assist the therapist in understanding your child?

_____

_____

Please check behaviors and symptoms that occur to your child/adolescent more often than you would like them to take place.

☐Aggressive
☐Angry
☐Anxiety
☐Bedwetting
☐Blinking, jerking
☐Bullies, threatens
☐Careless, reckless
☐Chest pains
☐Clumsy
☐Cyber addiction
☐Defiant
☐Depression
☐Destructive
☐Difficulty speaking
☐Dizziness
☐Eating disorder
☐Excessive masturbation
☐Expects failure
☐Fatigue
☐Fearful
☐Frequent injuries
☐Frustrated easily
☐Hallucinations
☐Head banging
☐Heart problems
☐Hopelessness
☐Hurts animals
☐Imaginary friends
☐Impulsive
☐Irritable
☐Lazy
☐Learning problems
☐Lies frequently
☐Loner
☐Low self-esteem
☐Messy
☐Moody
☐Nightmares
☐Oppositional
☐Overactive
☐Overweight
☐Panic attacks
☐Phobias
☐Poor appetite
☐Quarrels
☐Sad
☐Selfish
☐Separation anxiety
☐Sets fires
☐Sexual acting out
☐Sick often
☐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
☐Ticks or twitching
☐Unsafe behaviors
☐Unusual thinking
☐Weight loss or gain
☐Withdrawn
☐Worries excessively
☐Other

_____

_____