The Northwest Catholic Counseling Center

Serving all regardless of faith or finances

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

8383 N.E. Sandy Boulevard, Suite 205 • Portland, Oregon 97220 • 503.253.0964
www.nwcounseling.org

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

_____

_____