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 ☐ Other Pronouns: _____

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

Person completing this form:_____

Relationship to child/adolescent:_____

Mother's Name:_____

Best phone # to reach: ☐ (cell) ☐ (home) _____-_____-_____

May we leave a message? ☐ Yes ☐ No

Father's Name:

Best phone # : ☐ (cell) ☐ (home) _____ - _____ - _____

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 to receive notification?

Who: _____ How: _____

Ethnicity: ***(Choose all that apply:***

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Hispanic or Latino ☐ Native Hawaiian or Pacific Islander ☐ White
☐ Multi-ethnic _____
☐ Other _____
☐ Prefer not to answer

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

Office use only:		
___ Entered in FM	___ Entered in TH	___ Scanned

Name of pediatrician: _____

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

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

If yes, please list all medications and dosages.

Medications:	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

_____