

Case Number: \_\_\_\_\_

WINKE COUNSELING SERVICES PC  
CHILD & ADOLESCENT HISTORY

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Person Completing Form: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Who is the custodial parent? \_\_\_\_\_

What are the problems your child is having? \_\_\_\_\_

Are parents/guardians willing to participate in treatment? \_\_\_\_\_

What are your goals / expectations for your child's counseling? \_\_\_\_\_

FAMILY

	Name	Age	School/Employer	Marital Status
Mother				
Father				
Step-Parent(s)				
Brothers/Sisters				

Others living in the home: \_\_\_\_\_

Case Number: \_\_\_\_\_

**BIRTH & DEVELOPMENT**

Pregnancy: Normal? \_\_\_\_\_ Early Development: Normal? \_\_\_\_\_

If complications, please explain (if premature include weeks and weight): \_\_\_\_\_

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Any prenatal exposure to alcohol, tobacco, or drugs? \_\_\_\_\_

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Infancy & Development: Any problem areas?

- |  |                                       |   |                                       |
|--|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Colic                     | <input type="checkbox"/> Underactive  | <input type="checkbox"/> Chronic Illness  | <input type="checkbox"/> Malnutrition |
| <input type="checkbox"/> Eating                    | <input type="checkbox"/> Infections   | <input type="checkbox"/> High Fevers      |                                       |
| <input type="checkbox"/> Sleeping                  | <input type="checkbox"/> Slow Growth  | <input type="checkbox"/> Hospitalizations |                                       |
| <input type="checkbox"/> Mild or<br>food allergies | <input type="checkbox"/> Fussy        | <input type="checkbox"/> Surgeries        |                                       |
|  | <input type="checkbox"/> Constipation | <input type="checkbox"/> Overactive       |                                       |

**PHYSICAL HEALTH**

Last date seen by physician and reason for seeing: \_\_\_\_\_

Medical Conditions (past & present, include surgeries, hospitalizations, and treatment procedures): \_\_\_\_\_

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Any history of head injuries, concussions, or traumatic brain injuries?

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Current medications & dosages (include over the counter medications and supplements):

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Family history of illness (including mental health and substance abuse): \_\_\_\_\_

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Is your child allergic to or have had a bad reaction to any medications?  Yes  No If yes, please list: \_\_\_\_\_

Case Number: \_\_\_\_\_

Are immunizations up to date?  Yes  No \_\_\_\_\_

Has your child had vision and hearing exams? Results: \_\_\_\_\_

Has your daughter begun menstruation?  Yes  No Age of onset: \_\_\_\_\_

Do you know your child to be sexually active  Yes  No \_\_\_\_\_

\*In the event of pregnancy during treatment, it is important to inform the doctor if taking any medication.

**RELIGIOUS AND SPIRITUAL**

Mother's Background \_\_\_\_\_ Father's Background \_\_\_\_\_

Does the family practice religion or spirituality? Please describe: \_\_\_\_\_

Does your child participate? \_\_\_\_\_

**CULTURAL/ETHNIC BACKGROUND**

What is the ethnic group(s) of child's parents? \_\_\_\_\_

Does your child identify with this same group, or another? \_\_\_\_\_

**LEISURE/RECREATIONAL**

Hobbies, leisure time activities, interests: \_\_\_\_\_

Has his / her of activity level changed?  Yes  No If yes, explain how: \_\_\_\_\_

**LEGAL**

Has your child ever been involved with the police or courts? Explain: \_\_\_\_\_

Has your child been part of a divorce or custody issue? \_\_\_\_\_

Is your child adopted? \_\_\_\_\_ When were they told? \_\_\_\_\_

**FAMILY INCOME**

Does your child work?  Yes  No Hours: \_\_\_\_\_ Position: \_\_\_\_\_

Does the family have financial difficulties?  Yes  No

**SCHOOL**

School District: \_\_\_\_\_ School: \_\_\_\_\_

Present Grade: \_\_\_\_\_ Repeated a grade? \_\_\_\_\_ Present grades? \_\_\_\_\_

How does your child feel about school? \_\_\_\_\_

Has your child ever had difficulties with:  Math  Reading  Language  Speech  Hearing  
\_\_\_\_\_

Has your child ever received special education services?  Yes  No

Does your child have a current IEP or 504 Plan?  Yes  No

Have you received complaints or compliments from your child’s school about behavior or achievement?

Please explain: \_\_\_\_\_

Has your child ever been afraid to go to school? \_\_\_\_\_

Has your child ever been the victim of bullying? \_\_\_\_\_

**BEHAVIOR**

Please check any of the following that are typical of your child’s behavior:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Does not feel liked              | <input type="checkbox"/> Does not feel like self | <input type="checkbox"/> Poor hygiene                     |
| <input type="checkbox"/> Feels lonely                     | <input type="checkbox"/> Easy to anger           | <input type="checkbox"/> Sleep difficulties               |
| <input type="checkbox"/> Shy with children                | <input type="checkbox"/> Stubborn                | <input type="checkbox"/> Sleep walking                    |
| <input type="checkbox"/> Prefers to be alone              | <input type="checkbox"/> Defiant                 | <input type="checkbox"/> Bedwetting – present             |
| <input type="checkbox"/> Worries                          | Aggressive with:                                 | <input type="checkbox"/> Bedwetting – past                |
| <input type="checkbox"/> Moody                            | Peers _____                                      | <input type="checkbox"/> Soiling                          |
| <input type="checkbox"/> Sad                              | Siblings _____                                   | <input type="checkbox"/> Unusual thinking                 |
| <input type="checkbox"/> Cries easily                     | Adults _____                                     | <input type="checkbox"/> Unusual behaviors                |
| <input type="checkbox"/> Expects failure                  | <input type="checkbox"/> Needs the last word     | <input type="checkbox"/> Violent behavior                 |
| <input type="checkbox"/> Does not share                   | <input type="checkbox"/> Stealing from home      | <input type="checkbox"/> Destruction of property          |
| <input type="checkbox"/> Lacks motivation                 | <input type="checkbox"/> Will not admit blame    | <input type="checkbox"/> Not always truthful              |
| <input type="checkbox"/> Sexual acting out                | <input type="checkbox"/> Sets fires              | <input type="checkbox"/> Fails to understand consequences |
| <input type="checkbox"/> Preoccupied with sexual thoughts | <input type="checkbox"/> Poorly organized        | <input type="checkbox"/> Feelings of guilt                |
|   | <input type="checkbox"/> Clumsy                  |   |

- \_\_\_ Tics or twitches      \_\_\_ Takes unnecessary risks      \_\_\_ Acts impulsively
- \_\_\_ Compulsive behavior      \_\_\_ Short attention span      \_\_\_ Overactive
- \_\_\_ Talks impulsively      \_\_\_ Daydreams      \_\_\_ Perfectionist
- \_\_\_ Jealousness

Has your child ever used alcohol, tobacco, or drugs? Please specify type, amount, and frequency: \_\_\_\_\_

**PERSONAL ADJUSTMENT**

How does your child relate to: Mother? \_\_\_\_\_ Father? \_\_\_\_\_

Step parent(s)? \_\_\_\_\_ Siblings? \_\_\_\_\_

Authority Figures? \_\_\_\_\_ Peers? \_\_\_\_\_

**COUNSELING/PRIOR TREATMENT HISTORY**

How does your child feel about counseling? \_\_\_\_\_

Has your child had psychotherapy/counseling or attended a support group before?  Yes  No If yes, please list below:

Name of Center	Type of Service Outpatient/inpatient/Day Treatment	Dates	Drug or Alcohol Treatment (Y/N)

Has your child ever experienced thoughts of harming him/herself or another person?  Yes  No If yes, please explain: \_\_\_\_\_

Does your child have a history of suicide attempts or harming others?  Yes  No

If yes, please describe: \_\_\_\_\_

Has your child ever experienced or witnessed trauma, physical or sexual abuse? \_\_\_\_\_

Case Number: \_\_\_\_\_

Is there anything else you would like us know about your child? \_\_\_\_\_

\_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_

Date

\_\_\_\_\_

-For Office Use-

\_\_\_\_\_  
Therapist's Signature

Date

Based on the information provided above, a physical exam  Is Required  Is Not Required

M.D./D.O. Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Physician Signature

Date

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