MINOR PERSONAL HISTORY

SOURCE: __Behavioral Health _____

Client name _____ Date of birth _____

Gender: ☐ Male ☐ Female ☐ Other Grade in school _____

Hearing and/or vision difficulties: ☐ Hearing _____ ☐ Vision _____

Requires assistance to get around: ☐ None ☐ Yes _____

Form completed by (if other than client) _____

Referring provider _____

Primary reason(s) for seeking services:

☐ Addictive behaviors	☐ Coping	☐ Fear/phobias	☐ Sleeping problems
☐ Alcohol/drugs	☐ Depression	☐ Hyperactivity	☐ Other mental health concerns
☐ Anger management	☐ Eating disorder	☐ Mental confusion	_____
☐ Anxiety	☐ Excessive gaming	☐ Sexual concerns	

Family History

Parents: *Name, date of birth, address (note if same as child) and phone*

Parent #1 _____

Parent #2 _____

Are parents currently:

☐ Married ☐ Together, not married ☐ Separated ☐ Divorced ☐ Never together

Please list all who live in your household *(name, relationship, age)*:

_____

_____

Please list all family members *(siblings, etc.)* who reside outside the household *(name, relationship, age)*:

_____

_____

Family Mental Health History

Please list known mental health and substance abuse/chemical dependency issues within the immediate and extended family.

Paternal side:

_____

_____

Maternal side:

_____

_____

MINOR PERSONAL HISTORY

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Military Involvement

Were the parent(s) or close family member of this child in the military? ☐ Yes ☐ No

Active in combat or deployment: ☐ Yes ☐ No Years of service _____

What was the military occupational specialty (MOS)? _____

Pregnancy/Birth

Was the pregnancy with child planned? ☐ Yes ☐ No Length of pregnancy _____

History of miscarriage? ☐ Yes ☐ No Stillborn or infant death? ☐ Yes ☐ No

While pregnant, did the mother have adequate financial, emotional, medical and nutritional support?
☐ Yes ☐ No

Any other maternal health concerns during pregnancy? _____

Any known fetal exposure to: ☐ Alcohol ☐ Inhalants *(cigarette/cigar/pipe/vape/marijuana, etc.)*
☐ Prescription and/or non-prescription drugs If yes, amount _____

Induced labor? ☐ Yes ☐ No Cesarean? ☐ Yes ☐ No

Baby's birth weight _____ Birth length _____

Describe any physical or emotional complications with the delivery:

_____

_____

Describe any complications for the mother or baby after birth:

_____

_____

Developmental History

Did developmental milestones occur within normal timelines? ☐ Yes ☐ No

If no, describe _____

Are there any special, unusual or traumatic circumstances that affected your child's development?
If yes, describe _____

Is there a history of abuse of this child? ☐ Yes ☐ No
If yes: ☐ Sexual ☐ Physical ☐ Verbal If yes: ☐ Victim ☐ Perpetrator ☐ Both

Other childhood issues: ☐ Neglect ☐ Inadequate nutrition, clothing, shelter, other _____

Education

Current school _____

Type of school: ☐ Public ☐ Private ☐ Home schooled ☐ Other _____

Grade _____ Teacher _____ School counselor *(if known)* _____

Does the child have an IEP? ☐ Yes ☐ No If yes, what type _____

MINOR PERSONAL HISTORY

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Have there been any recent changes in the child's grades? ☐ Yes ☐ No
If yes, describe _____

Culture/Ethnicity
Are there any specific concerns related to culture or ethnicity issues? ☐ Yes ☐ No
If yes, describe _____

Spiritual/Religious
How important are spiritual matters to your child? ☐ Not ☐ Little ☐ Moderate ☐ Very

Are there any specific concerns related to spiritual or religious issues? _____

Self-Identity
How does your child identify as far as race? _____ Gender identity? _____

Sexual orientation? _____ Any concerns related to these? _____

Legal
Are you or a family member currently involved in any of the following legal issues? ☐ Child protection
☐ Family court ☐ Parental custody ☐ Criminal ☐ Other _____

Nutrition
Has your child gained or lost a large amount of weight over the past three months? ☐ Yes ☐ No

Are there any specific concerns related to nutritional intake? ☐ Yes ☐ No
If yes, describe _____

Does your child consume caffeine? ☐ Yes ☐ No If yes, describe _____

Chemical Use
What alcohol or other drugs has your child used? _____

Has your child been to treatment for alcohol or other drug use? ☐ Yes ☐ No
If yes, where, when and explain the outcome _____

What tobacco products does/did your child currently or historically use? ☐ Cigarettes ☐ Chewing tobacco
☐ Inhalants (vapes) ☐ Other _____ Frequency of use _____

Prior Psychiatric or Psychological Services *(past and present)*
Has your child been hospitalized for psychiatric treatment? ☐ Yes ☐ No
If yes, when and where _____

Has your child been in individual or group therapy in the past? ☐ Yes ☐ No
If yes, when and where _____

To your knowledge, has your child had suicidal thoughts or attempted suicide? ☐ Yes ☐ No
If yes, describe _____

MINOR PERSONAL HISTORY

SOURCE: __Behavioral Health _____

To your knowledge, does your child engage in self-harm behaviors? ☐ Yes ☐ No
If yes, describe _____

To your knowledge, has your child had thoughts of harming others or engaged in harming others?
☐ Yes ☐ No If yes, describe _____

Behavioral/Emotional

Please check any of the following that are typical for your child:

☐ Affectionate
☐ Aggressive
☐ Alcohol problems
☐ Angry
☐ Anxiety
☐ Attachment to dolls
☐ Avoids adults
☐ Bed wetting
☐ Bizarre behavior, such as _____
☐ Bullies/threatens
☐ Careless/reckless
☐ Chest pains
☐ Clumsy
☐ Confident
☐ Cooperative
☐ Computer addiction
☐ Defiant
☐ Depression
☐ Destructive
☐ Difficulty speaking
☐ Distractible
☐ Drug use
☐ Easily frustration
☐ Eating disorder
☐ Enthusiastic
☐ Excessive gaming
☐ Excessive masturbation
☐ Expects failure
☐ Fatigue
☐ Fearful
☐ Frequent injuries
☐ Gambling
☐ Generous
☐ Hallucinations
☐ Head banging
☐ Headaches
☐ Hyperactivity
☐ Hurts animals
☐ Imaginary friends
☐ Impulsive
☐ Irritable
☐ Lazy
☐ Learning problems
☐ Lies frequently
☐ Listens to reason
☐ Loner
☐ Low self-esteem
☐ Messy
☐ Moody
☐ Nightmares
☐ Obedient
☐ Often sick
☐ Oppositional
☐ Overweight
☐ Preoccupied with objects
☐ Panic attacks
☐ Phobias
☐ Poor appetite
☐ Physical fights with others
☐ Sad
☐ Selfish
☐ Separation anxiety
☐ Sets fires
☐ Sexual identity problems
☐ Sexual acting out
☐ Shares
☐ Sick often
☐ Short attention span
☐ Shy/timid
☐ Sleeping problems
☐ Slow moving
☐ Soiling
☐ Speech problems
☐ Steals
☐ Stomach aches
☐ Suicidal attempts
☐ Suicidal threats
☐ Talks back
☐ Teeth grinding
☐ Thumb sucking
☐ Tics or twitching
☐ Thrill seeking behaviors
☐ Unusual thinking
☐ Weight loss
☐ Withdrawn
☐ Worries excessively
☐ Other _____

Please describe any of the above (or other) concerns:

_____
_____

MINOR PERSONAL HISTORY

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Stressors/Trauma

Have there been any other significant changes, events or stressors in your child's life? *(Family conflict, divorce, medical problems, moving, fire, death of family member, witness of tragic event, etc.)* ☐ Yes ☐ No
If yes, describe _____

Are there special, unusual or traumatic circumstances that have affected your child? ☐ Yes ☐ No
If yes, describe _____

Goals/Additional Services

Any additional information you believe would assist us in understanding your child?

_____
_____
_____

What are your goals for the child's therapy or psychological testing evaluation?

_____
_____
_____

Are there additional services you hope to obtain for your child at this time? ☐ Yes ☐ No
If yes, explain _____

_____ _____
Signature of parent, guardian or caregiver Date