

Alliance Counseling & Coaching

Channahon – Joliet – Plainfield – Morris

HISTORY FOR THERAPY ASSESSMENT

Child/Adolescent

IDENTIFYING INFORMATION:

Client:

Name: _____ Date: _____

Address: _____

City/State/Zip: _____

Home phone: _____ Cell phone: _____

Age: _____ Date of Birth: _____ Gender: _____

Email: _____

Mark preferred method of contact, may choose more than one

___ When contacted, do not mention agency name ___ Text Message

___ Phone ___ Email Additional Email _____

Father's Name: _____

Address: _____

Home phone: _____ Cell phone: _____

Mother's Name: _____

Address: _____

Home Phone: _____ Cell phone: _____

Name of legal guardian(s): _____

Address if different from above: _____

Home phone: _____ Cell phone: _____

Is legal guardianship shared? If yes with whom: _____

Insurance Policy Holder:

Name: _____ Date of Birth: _____

Address: _____

Home phone: _____ Cell phone: _____

Social Security Number: _____

*****Please put an "X" in the box next to the party responsible for balance.**

Emergency Contact:

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____

How did you hear about Alliance Counseling & Coaching?

Internet Phone book Doctor Friend Other: _____

Presenting Issue for Counseling (why you brought your child in for counseling):

SYMPTOMS/LIFE ISSUES:

- Headaches Depressed Feel panicky Sexual Acting Out
- Clingy behavior Tiredness Shy Home conditions bad
- Vision problems Nightmares Can't make decisions Can't keep job
- Bowel disturbance Can't sleep Anxious Self harm
- Stomach trouble Fainting spells Aggression Alcoholism
- Fast Heartbeat Hearing difficulty Overambitious Drugs
- Dizziness Feel inferior Lonely Bedwetting/soiling

PREVIOUS MENTAL HEALTH TREATMENT:

Therapist	Location	Dates	Outcome

PSYCHIATRIC HOSPITALIZATION? (List All)

Psychiatric Hospital	Date	Reason for Admission	Length of Stay

Suicidal thoughts: Past? Present? Explain: _____

Suicidal attempts: Method Used? _____ When? _____

Where? _____ How was it stopped? _____

Hospitalization? _____

Please Explain: _____

Self harming behavior: Past? Present? Explain: _____

CURRENT PSYCHIATRIC MEDICATIONS:

Name	Type/Purpose	Dosage Taken	Frequency Taken

History of mental illness in family? Yes No Please describe: _____

CURRENT/PAST MEDICAL OR PHYSICAL PROBLEMS/CONDITIONS:(i.e. allergies, seizures, high blood pressure, diabetes, cardiac problems TB, etc) _____

Name of Medical Doctor _____ Phone: _____

Name of Psychiatrist _____ Phone: _____

Date of last physical exam: _____ Where: _____ Doctor: _____

CURRENT MEDICATIONS, VITAMINS, & OVER THE COUNTER:

Name	Purpose	Dosage Taken	Frequency Taken	Prescribed by

Health Behavior (Be specific, No. of ounces, etc.):

Nicotine _____ Caffeine _____ Beer _____ Wine _____

Liquor _____ Marijuana _____ Speed/Downers _____ Other drugs _____

Prescription medications: _____

Nutrition Poor Adequate Excellent If poor, please explain _____

Exercise Poor Adequate Excellent If poor, please explain _____

Sleep issues? (night terrors, insomnia, etc.) _____

FAMILY:

	<i>Name</i>	<i>Birth date</i>	<i>Age</i>	<i>Sex</i>	<i>Living or Dead</i>	<i>Marital Status</i>
<i>FATHER</i>						
<i>MOTHER</i>						
<i>LEGAL GUARDIAN</i>						
<i>STEP PARENTS (if applicable)</i>						
<i>BROTHERS and/or SISTERS</i>						
<i>OTHERS: (Stepbrother & Sisters)</i>						

Describe each parent in three words (indicate if step-parent):

Mother _____

Father _____

Which parent are you closest to? _____

Describe relationship with parents. Past/Current _____

Describe parent's relationship to each other: _____

What is your birth order? _____

Describe past/current relationship with siblings _____

Any history of physical/sexual/emotional abuse? Yes No Describe: _____

Who is child's best friend? _____

Do parents approve of their friends? _____

Describe significant life events: _____

Has child/adolescent lost someone through death? _____

How did they handle that situation? _____

Sexual History: (If applicable)

Describe your parents attitudes towards sex: _____

How did you learn about sex: _____

Any frightening or unpleasant sexual experiences? _____

Any abuse or trauma? _____

If applicable: Pregnancies _____ Miscarriages _____ Abortions _____

(Number of each)

Work History: (If applicable)

Are you currently employed? _____ If so where? _____

Type of work? _____

If employed, do you like your job? _____

Education

Current grade: _____ Ever been held back? _____

Issues at school with other students/teachers/performance/behavior? _____

Legal

Any current legal problems? (ie, court order, probation/parole, guardianships, arrest, order of protection, truancy): _____

Please describe any violent/aggressive behavior and the frequency: _____

Please list child/adolescents strengths:

Any other important information your counselor should know about your child/adolescent?

Client signature (if client is 14 years old or older): _____

Parent/Legal Guardian signature: _____

(If minor under age 18 years)

Date: _____