Alliance Counseling & Coaching of Illinois

Channahon – Joliet – Morris – Ottawa

HISTORY FOR THERAPY ASSESSMENT

Child/Adolescent

IDENTIFYING INFORMATION:

Client:

Name:_____Date:_____

Address:_____

City/State/Zip:_____

Home phone:_____ Cell phone:_____

Age:_____ Date of Birth:_____ Gender:_____

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:_____

Emergency Contact:

Name:_____Relationship:_____

Home phone:_____ Cell phone:_____

Do we have your consent to leave messages on voicemail (Circle Preference) Home Cell

If no please indicate no _____

How did you hear about Alliance Counseling & Coaching of Illinois?

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 HOSPITILIZATION? (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?_____

Hospitilization?_____

Please Explain:_____

Self harming behavior: Past? Present? Expalin:_____

_____

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

FAMILY:

	Name	*Birth date*	*Age*	*Sex*	*Living or Dead*	*Marital Status*
FATHER						

MOTHER						
LEGAL GUARDIAN						
STEP PARENTS (if applicable)						
BROTHERS and/or SISTERS						
OTHERS: (Stepbrother & Sisters)						

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)

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) _____

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:_____