HOLY FAMILY COUNSELING CENTER
4411 Suwanee Dam Rd, Suite 720
Suwanee, GA 30024 | (678) 993-8494

History and Assessment for a Minor

Child's Name: ______________________________ **Date:** ______________

Sex: M/F **Age:**____ **DOB:** ____/____/_____ **Biological Child Y/N** **If adopted, at what age** _____

Parents' Names (please include step-parents if applicable):

______________________ ______________________

______________________ ______________________

Please describe custody and visitation if applicable:

____

____

Primary reason you are concerned about your child:

____

____

Referred by: ______________________________

Brothers and Sisters

First Name	Last Name	Sex	Age	Relationship (full, half, step)

Child's Name: ____

Symptom/Problem Checklist
(Please mark with a C if it's a current problem and/or P if it's been a problem in the past)

______Sleep problems
______Lack of interest in activities
______Unassertive
______Fatigue/low energy
______Concentration problems
______Appetite/weight changes
______Withdrawn

______Morbid thoughts
______Suicidal thoughts or threats
______Suicidal plans / attempts
______Cries easily
______Mood swings
______Self-harm
______Excessive sadness or depression

______Forgetful/memory problems
______Short attention span
______Aggressive behavior
______Can't sit still
______Not interested in peers
______Picked on / bullied by peers

______Talks excessively / interrupts
______Irritable
______Impulsive
______Difficulty following rules
______Problem completing schoolwork
______Easily distracted

______Excessive worry/fearfulness
______Anxiety or panic attacks
______Social fears, shyness
______Separation problems
______Bedwetting / soiling
______Headaches, stomachaches
______Odd beliefs / fantasizing

______Nightmares
______Frequent tantrums
______Resistant to change
______School refusal
______Perfectionism
______Odd hand / motor movements
______Hallucinations

______Lying
______Running away
______Blames others for mistakes
______Argumentative
______Defiant
______Hurting others; fighting
______Angry and resentful

______Swearing
______Stealing
______Cheating
______Destructive
______Acts as if has no fear
______Short tempered
______Easily annoyed / annoys others

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Child's Name: ____

School History: List all past schools the child has attended

Name of School	Dates of Attendance

Has the child repeated a grade? Y / N If yes, what grade? ______

Has the child ever received special education/resource services? Y / N

What individualized services is the child currently receiving? (Circle all that apply)

Resource Center Speech Therapy Occupational Therapy Tutoring

Please describe any problems the child has had in school

____

____

What does your child enjoy doing? (e.g., sports, outdoor play, music, choir, art, videogames, reading, pretend play, puzzles)

____

____

Health History

Who cared for the child in the first two years of life? ____________________________
During the first two years of life, did the child experience any of the following?
_____ Maternal depression _____Abuse _____Chronic pain
_____ Stressful home environment _____Neglect _____Chronic illness
_____ Separation from parents or primary caregiver

Date of last physical exam: _________________
Vision Problems? Y / NHearing Problems? Y / N Dental Problems? Y / N
If yes, please describe: ____

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Child's Name____________________________

Has the child ever had a head injury or concussion? Y / N
If yes, please describe: ____

Has the child had a serious illness or injury? Y / N
If yes, please describe: ____

Has the child ever been hospitalized? Y / N
If yes, please describe: ____

Is the child currently taking any medications? Y / N
If yes, please list name, dosage, and reason.
____

____

About how many hours per week does the child spend time with electronic devices? ____________________

What rules have you set regarding use of electronic devices? ____________________________________

____

Does the child have his/her own mobile phone? Y / N
If yes, are parental controls or filters set up? Y / N

Are you afraid someone you know may injure/harm this child? Y / N

Has the child received any previous therapy or psychiatric treatment? Y / N
If yes, please describe: ____
Has the child been tested by a psychologist? Y / N If yes, when? ________________________________

Does the child use alcohol or drugs? Y / N
Has the child ever witnessed domestic violence, whether physical or verbal? Y / N

Family History
Chemical Use (Now and/or past)? N / Y If Yes, which parent? ________________
Type: Alcohol _____ Marijuana _____ Other drugs ______________________
List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drug addiction, ADHD, schizophrenia, etc.):

Illness or Addiction	Relationship to child
______________________________	______________________________
______________________________	______________________________

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Child's Name: ___________________________

How is your child disciplined? Please list each method and frequency of use:

____

____

What are your child's strengths?

____

____

Life Stressors and Trauma History

Has your child been verbally abused? Y / N Suspected?_____
Has your child been physically abused? Y / N Suspected?_____
Has your child been sexually abused? Y / N Suspected?_____

Other Stressors or traumas? Y / N If yes, please describe: ______________________________________

____

Other comments or information that could be helpful? ______________________________________

____

____

Name of person completing form: ____________________________________

Relationship to child: ____

Signature: ____________________________________ **Date:** ______________