the Center
for Christian Counseling, Consultation & Training, Inc.

4868 High Crossing Blvd.
Madison, WI 53704
608.274.8294
608.274.8783 Fax

CHILD INDIVIDUAL AND FAMILY HISTORY

Name of Child: _____

Date: _____ DOB: _____

Please answer the following questions thoroughly. If you need more space please attach additional information to this form. It is very important that you bring this completed form to your child's first counseling session.

Identifying Information

Name of person completing this form:	
Mother's Name: Age:	Father's Name Age:
Mother's Occupation:	Father's Occupation:
Name of any other significant care giver(s) to the child:	Describe the relationship(s) to the child:
Are both parents living in the same household as the child?	
If not, please describe visitation schedule. (Attach additional sheet if needed)	
Who has custody of the child?	
Who makes the medical decisions for the child?	
If divorced, age of child at time of divorce:	

Concerns and Resources

What concerns do you have for this child?
What strengths does this child have?

Family and Household

Sibling Name	Age	Relationship to the child	Where does this sibling live?

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Family (not child's) History of Mental Health, Violence, Abuse or Substance Abuse

Describe	Relationship to child

Cultural and/or Spiritual

Do you have any cultural and/or spiritual beliefs that are important to your child's progress in therapy? Y N
If so, please identify and describe how:

Academic

Grade level and Name of school List any other schools attended in the past	Did or does child require IEP assistance? Explain briefly:
Contact person:	Teacher's Name:
Would you like me to coordinate services with the school or provide updates? Y N	

Medical

Physician Name	Date of last visit
Specialist Name	Date of last visit
Psychiatrist Name	Date of last visit
Medication(s) (dosage, when taken, how long child has taken):	
What are the current medical concerns?	
Would you like me to coordinate treatment and services with your child's physician or psychiatrist? Y N	
On average, how many hours of sleep does the child receive daily? _____	
Does the child have trouble falling asleep at night? _____ Yes _____ No If yes, how long has this been a problem?	
Describe the child's appetite (during the past week): _____ Poor appetite _____ Average appetite _____ Large appetite	

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History of Services

Has the child been to counseling, treatment or in the hospital before?			Y N
If so, please provide the following information:			
Name and Address of counselor or facility	Purpose	Date: From-To	Outcome

Legal

Has the child been involved in the legal system for any reason?			Y N
If so, please provide the following information:			
What happened?	Where?	Date: From-To	Outcome

Experiences, Symptoms, and Risk Factors

Please circle "yes" or "no" in reply to whether your child has experienced any of the following:

Accidents (stitches, loss of consciousness)	Yes	No	Physical Limitations	Yes	No
Significant Illnesses	Yes	No	Head Injury	Yes	No
Infectious Disease	Yes	No	Significant mood change	Yes	No
Hospitalizations/Surgeries	Yes	No	Memory difficulties	Yes	No
Allergic reactions	Yes	No	Learning disabilities	Yes	No
Eating problems	Yes	No	Significant weight loss or gain	Yes	No
Physical Abuse	Yes	No	Language difficulties	Yes	No
Sexual Abuse	Yes	No	Significant behavior change	Yes	No
Sleeping more or less than usual	Yes	No	Physical complaints (no medical concerns)	Yes	No
Seizures/Tics/Neurological conditions	Yes	No	Headache, stomach ache, dizziness	Yes	No
Complains of loneliness	Yes	No	Removal from family/adoption/foster care	Yes	No
Behavior problems at school	Yes	No	Peer problems	Yes	No
Panic or anxiety attack	Yes	No	Intense fear of something	Yes	No
Difficulty with change or transitions	Yes	No	Too friendly with strangers	Yes	No
Aversive to touch, taste, texture	Yes	No	Talks about sex too much	Yes	No
Nightmares	Yes	No	Anxious about separating from adult	Yes	No
Sleep walking	Yes	No	Neglect, emotional or psychological abuse	Yes	No
Excessive worry	Yes	No	Hears or sees things that others don't	Yes	No
Obsessions	Yes	No	Has strange or odd beliefs or activities	Yes	No
Moved many times	Yes	No	Victim of racism	Yes	No
Refugee	Yes	No	Homelessness or living in a shelter	Yes	No
Assault (including sexual assault)	Yes	No	Prostitution or Pornography	Yes	No
Death of care giver	Yes	No	Sexual acting out	Yes	No
Change of language	Yes	No	Losses (person, place or thing of Significant to child)	Yes	No
Alcohol experimentation	Yes	No	Drug experimentation	Yes	No
Alcohol abuse	Yes	No	Drug abuse	Yes	No
Witnessing or hearing family violence	Yes	No	Witnessing War or Gang violence	Yes	No

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Traumatic experience	Yes	No	Suicidal thoughts or attempts	Yes	No
Thoughts of hurting others	Yes	No	Cruel to animals	Yes	No
Enuresis (wetting self past 5 years)	Yes	No	Encopresis (soiling self past 4 years)	Yes	No
Self injurious acts	Yes	No	Setting a fire	Yes	No
Sudden outbursts of anger	Yes	No	Avoiding thoughts or feelings	Yes	No
Recurring thoughts or images of trauma	Yes	No	Acting out traumatic event in plays	Yes	No
Spacing out (lost time, day dreaming)	Yes	No	Hyper vigilance (notices everything)	Yes	No
Easily startled	Yes	No	Feeling detached from others	Yes	No
Breaks things of others	Yes	No	Steals from others	Yes	No
Breaks own things	Yes	No	Bragging/Boasting	Yes	No
Makes up stories or lying for no gain	Yes	No	Acts too young	Yes	No
Argues a lot—more than others	Yes	No	Acts in a secretive way	Yes	No
Screams or cries a lot	Yes	No	Suspicious of others	Yes	No
Easily embarrassed by others	Yes	No	Eats, chews or drinks things that are not food	Yes	No
Swears or uses foul languages	Yes	No	Seems to do the opposite of what's asked	Yes	No
Gets into fights with others	Yes	No	Has temper tantrums or melt downs	Yes	No
Hangs around others who get into trouble	Yes	No	Threatens others	Yes	No
Sucks thumb at an older age	Yes	No	Too concerned about cleanliness	Yes	No
Truancy is an issue or skips school	Yes	No	Picks at or scratches self-nose, skin, hair	Yes	No
Plays with sex parts in public	Yes	No	Does not finish projects	Yes	No
Lacks coordination (not due to medical)	Yes	No	Exposes self to others	Yes	No
Acts like opposite sex	Yes	No	Desires to be opposite sex	Yes	No
Prefers older or younger children	Yes	No	Runs away from home	Yes	No
Avoids others	Yes	No	Avoids leaving home	Yes	No

Child Strengths and Protective Factors

Please circle "yes" or "no" to whether the following describe your child:

Has consistently supportive caregiver	Yes	No	Likes school	Yes	No
Getting along well with others	Yes	No	Is familiar with neighbors	Yes	No
Lives in a supportive neighborhood	Yes	No	Acts responsibly	Yes	No
Has a positive role model or hero	Yes	No	Does well in school and like learning	Yes	No
Able to protect self emotionally	Yes	No	Able to get help when threatened	Yes	No
Abel to decrease conflict	Yes	No	Takes care of physical and hygiene needs	Yes	No
Able to seek out adult counsel	Yes	No	Has short term and long term goals	Yes	No
Has a creative and imaginative side	Yes	No	Displays empathy, friendship skills	Yes	No
Is easy going	Yes	No	Likes to get a job done	Yes	No
Shows concern for family or group	Yes	No	Transitions well with change	Yes	No
Has a sense of humor	Yes	No	Has a job or does chores	Yes	No
Caregivers are involved in school	Yes	No	Attends religious activities	Yes	No
Has a positive group of friends	Yes	No	Involved in youth activities	Yes	No
Reads for pleasure	Yes	No	Uses self-restraint	Yes	No
Resists negative peer pressure	Yes	No	Values character qualities	Yes	No
Positive outlook for self	Yes	No	Positive outlook for the future	Yes	No
Sense of purpose	Yes	No	Can describe personal power and control	Yes	No
Values diversity and uniqueness of others	Yes	No	Can make plans and carry them out	Yes	No
Values honesty	Yes	No	Values equity and justice		

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Developmental History

Please circle "yes" or "no" to reply to whether the child was exposed to any of these before birth.			
Drug or alcohol use by mother	Yes	No	If yes, please identify which drugs or alcohol.
Medication use by the mother	Yes	No	If yes, please identify which medications.
Health problems of the mother	Yes	No	If yes, please identify which health problems.
Pre-birth trauma of any kind	Yes	No	If yes, please describe.

Please circle "yes" or "no" to reply to whether the child was exposed to any of these at birth.			
Delivery problems	Yes	No	If yes, please describe the problems.
Infant medical problems	Yes	No	If yes, please describe the problems.
Early delivery	Yes	No	If yes, please identify how early.
Removal from mother at birth	Yes	No	If yes, please describe.

Please circle "yes" or "no" to reply to whether the child experienced any of these as a toddler.			
Crawling or walking delays	Yes	No	If yes, please describe.
Talking or speech difficulties	Yes	No	If yes, please describe.
Toilet training delays or problems	Yes	No	If yes, please describe.
Social delays or problems	Yes	No	If yes, please describe.
Soothing difficulties	Yes	No	If yes, please describe.
Calm infant	Yes	No	If yes, please describe.
Irritable infant	Yes	No	If yes, please describe.
Active infant	Yes	No	If yes, please describe.

Is there a history or recent occurrence(s) of child abuse to this child? _____ Yes _____ No
If Yes, which type(s) of abuse? _____ Verbal _____ Physical _____ Sexual
Comments: _____

Current Functioning

Please rate how you feel your child is functioning in the following areas using a number from 1 to 5.
1=no impairment, 2=mild impairment, 3=moderate impairment, 4=marked impairment, and 5=extreme impairment.

Parent Relationships		Family Financial Situation	
Peer Relationships		Involvement in activities	
Sibling Relationships		Physical Health	
School work		Personal Hygiene	
Eating Habits		Ability to concentrate	
Sleeping Habits		Body Image	
Ability to control his/her temper		Other _____	

Please indicate ea. caregiver's general disciplining style: A=Authoritarian D=Democratic P=Permissive
Caregiver/_____ = ____ Caregiver/_____ = ____
Please list the hobbies, activities, games or sports in which child is involved:

_____

Please list any organized activities such as church groups, clubs, after school programs, or group programs in which the child is involved:

_____

_____

Please list any chores or employment the child has:

_____

Thank you for providing this information. Some of these may be clarified by the therapist.