Eden Counseling Center

Patient Information & Social History

Child & Adolescent (17 years and younger)

When a therapist begins working with a child, we find that certain basic information provided to us by the parent can be useful. We greatly appreciate your time and cooperation with providing this information. We realize that some of the questions are difficult to remember and answer. Please try to give as many details as possible. The more we know about your child, the better job we can do.

PATIENT INFORMATION Name_____ Today's Date _____

Address _____

Patient's Address _____

Phone Number (Home) _____ Parent's Work/Cell Number _____

SS# _____ Birth date _____ Present Age _____ Weight_____ Height _____

Biological Father _____ Biological Mother _____

Other Guardian_____ Relationship _____

Primary Care Physician_____ Phone #_____

Address_____

Current health concerns_____ Date of last visit_____

Medications Prescribed _____

Previous or present Psychiatric or Psychological Services? ___ Yes ___No

If yes, Provider Name/Address_____

Present reason for seeking help _____

Problems your child is having at home_____

Problems your child is having at school _____

Is this a school referral? ___No ___Yes: If, yes, what is the reason for the referral_____

_____

RESPONSIBLE PARTY Name _____ Relationship to the patient_____

Social Security# _____ Birth Date_____ Employer_____

Address_____City_____State_____Zip_____

PARENTAL HISTORY

Biological Father_____ Birthplace _____ Birth date _____

Educational Attainment: _____

Did you have difficulty in school? ___ No ___Yes If yes, please explain: _____

_____

Did any member of your family have difficulty in school? ___No ___ Yes If yes, please explain:

_____

Place of Employment: _____ Occupation: _____Hours: _____

Other Marriages: _____

Past Physical or Mental Problems: _____

Biological Mother_____ Birthplace _____ Birth date _____

Educational Attainment: _____

Did you have difficulty in school? ___ No ___Yes If yes, please explain: _____

_____

Did any member of your family have difficulty in school? ___No ___ Yes If yes, please explain:

_____

Place of Employment: _____ Occupation: _____Hours: _____

Other Marriages: _____

Past Physical or Mental Problems: _____

PRESENT MARITAL SITUATION

___ Married & Living Together ___ Separated ___ Divorced ___ Widowed ___ Never Married

If married, number of years in present marriage: _____

Describe your present marriage: ___poor ___tolerate each other ___relatively happy ___happy ___very happy

Additional Comments: _____

If remarried since the birth of this child, how old was (s)he: when you divorced? _____ remarried? _____

If separated/divorced, who has primary physical custody? _____

Stepfather or Significant Other's Name _____

Stepmother or Significant Other's Name: _____

What are the legal custody arrangements? _____

BIRTH HISTORY

Birth: ___ Full term ___ Premature ___weeks Length of Labor: _____ Anesthesia? __Yes __ No

Complications during pregnancy: ___ None __ Bleeding ___ Special Medication ___ Toxemia

___ Diabetes ___ RH factor ___ Other: _____

Labor induced? ___No ___ Yes If yes, please give reason: _____

Problems immediately after birth? ___ No ___Yes If Yes, please explain: _____

Placed in an incubator? ___ No ___ Yes Birth Weight: _____ Fed normally? ___ No ___ Yes

When held, was (s)he: ___ Rigid ___ Relaxed Colic: ___ No ___ Yes If yes, how long: _____

Physical defects? ___ No ___ Yes If yes, please describe: _____

Irritability? ___ No ___ Yes Difficulty sleeping? ___ No ___ Yes If yes, please explain: _____

_____

CHILDHOOD HISTORY

At approximately what age did the following occur?

Held head up: _____ Crawled: _____ Sat Alone: _____ Walked: _____

First word: _____ Sentences: _____ Toilet Trained: _____ Dressed alone: _____

Difficulty using (check all that apply): ___ Scissors ___ Coloring ___ Writing ___ Other: _____

Comparison of development to that of brothers and/or sisters: _____

_____

Describe child as a toddler: _____

_____

Handed: ___ Left ___ Right High Fevers: ___ No ___ Yes

Convulsions/staring spells: ___ No ___ Yes Hearing Impairment: ___ No ___ Yes

Ear Infections: ___ No ___ Yes If yes, how many? _____

Visual impairment: ___ No ___ Yes If yes, please explain: _____

Speech impairment: ___ No ___ Yes If yes, please explain: _____

Injuries or accidents (particularly blows to the head): _____

_____

Describe child's health: _____

Describe any medical conditions: _____

Current medications and dosages: MD Prescribed _____

_____ _____ _____ _____

_____ _____ _____ _____

Allergies: _____

DAILY SCHEDULE

Sleep Pattern: ___ Normal ___ Very sound ___ Restless ___ Nightmares Number of Hours Sleep: ____

Bedtime: _____ Time of Waking: _____ Resist sleep? ___ No ___ Yes

Security Items? ___ No __ Yes If yes, please describe _____

General appetite and eating habits: _____

Child care arrangements: _____

CHURCH ATTENDANCE

Do you attend Church? ___ No __ Yes Name of Church_____

How often do you attend ?___ Regularly ___ Occasionally ___ Seldom ___ Never

Briefly describe your present involvement in your church _____

_____

FAMILY RELATIONSHIPS

List brothers and sisters in birth order and give their current ages:

_____ _____ _____

_____ _____ _____

Significant health or emotional problems with other children: _____

_____

Describe sibling rivalry or jealousy: _____

Does this child particularly like or relate well to any other brother or sister? ___ No ___ Yes.

If yes, please describe: _____

Do children generally get along? ___ Yes ___ No If no, please describe:_____

_____

Describe the father-child relationship: _____

Describe the mother-child relationship: _____

Describe relationship with significant caregiver: _____

Family Activities: _____

Activities with father: _____

Activities with mother: _____

Discipline Type: _____ Consistent? ___ No ___ Yes

Who administers discipline: _____

Child's reaction to frustration: _____

Child's Responsibilities: _____

Allowance? ___ No ___ Yes If yes, how much? _____ How is it used? _____

_____

Please list all people living in the household *(Use back of form to list additional information if necessary)*

Name	Age/Birth date	Grade Level	Relationship to patient

Describe home environment (house, apartment, ample play space, neighbors close by, type of neighborhood):

_____

Describe child's social relationships: _____

Describe child's bedroom (share a room, help pick-up, interest in decorating): _____

_____

Personality of Child (Check all that apply): ____anxious ____depressed ____extroverted ____introverted

____imaginative ____loner ____social ___ sensitive ____happy ____unhappy

Activity level of Child (Check all that apply): ___ active ____aggressive ___ difficulty remembering ___impulsive

___ loses things easily ___ organized ___ prefers quiet play

EDUCATIONAL INFORMATION

Present School_____ City_____

Grade level_____ Teacher's Name _____

School conference this year? ___No ___Yes: If yes, please describe outcome_____

_____Aca

demic progress: _____

Your expectations:_____

Schools Attended	Grade Level	Performance
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child's attitude toward school: _____

Unpleasant School Experiences: _____

Grades retained and why: _____

Most Difficult Subject: _____ Resist attending school? ___ No ___ Yes

Best Subject: _____ Reads other than assigned books? ___ No ____ Yes

Where does (s)he study: _____ Parents help? ___ No ____ Yes

Other comments on school: _____

Testing administered (school or private): _____

Additional information or comments: _____

_____

Parent or Guardian Name _____Signature_____Date_____