Case Number:__________

WINKE COUNSELING SERVICES PC
CHILD & ADOLESCENT HISTORY

Client Name:________________________________Date:___________Birth Date:________

Person Completing Form:______________________Relationship to child:________________

Who is the custodial parent?____

What are the problems your child is having?_____________________________________

____

Are parents/guardians willing to participate in treatment?_____________________________

What are your goals / expectations for your child's counseling?_________________________

____

FAMILY

	Name	Age	School/Employer	Marital Status
Mother				
Father				
Step-Parent(s)				
Brothers/Sisters				

Others living in the home:____

Case Number:__________

BIRTH & DEVELOPMENT

Pregnancy: Normal?________________Early Development: Normal?____________________

If complications, please explain (if premature include weeks and weight):____________________

____

____

Any prenatal exposure to alcohol, tobacco, or drugs?__________________________________

____

Infancy & Development: Any problem areas?

____Colic	____Underactive	____Chronic Illness	____Malnutrition
____Eating	____Infections	____High Fevers	
____Sleeping	____Slow Growth	____Hospitalizations	
____Mild or food allergies	____Fussy	____Surgeries	
	____Constipation	____Overactive	

PHYSICAL HEALTH

Last date seen by physician and reason for seeing:______________________________

Medical Conditions (past & present, include surgeries, hospitalizations, and treatment procedures):____

____

Any history of head injuries, concussions, or traumatic brain injuries?

____

Current medications & dosages (include over the counter medications and supplements):

____

____

Family history of illness (including mental health and substance abuse):______________

____

Is your child allergic to or have had a bad reaction to any medications? ☐Yes ☐No If yes, please list:____

Are immunizations up to date? ☐Yes ☐No____

Has your child had vision and hearing exams? Results: ______________________________

Has your daughter begun menstruation? ☐Yes ☐No Age of onset:______

Do you know your child to be sexually active ☐Yes ☐No ____________________________

*In the event of pregnancy during treatment, it is important to inform the doctor if taking any medication.

RELIGIOUS AND SPIRITUAL
Mother's Background_______________Father's Background_________________________

Does the family practice religion or spirituality? Please describe:____________________

Does your child participate?____

CULTURAL/ETHNIC BACKGROUND
What is the ethnic group(s) of child's parents?___________________________________

Does your child identify with this same group, or another?__________________________

LEISURE/RECREATIONAL
Hobbies, leisure time activities, interests:_______________________________________

____

Has his / her of activity level changed? ☐Yes ☐No If yes, explain how:________________

____

LEGAL
Has your child ever been involved with the police or courts? Explain:__________________

____

Has your child been part of a divorce or custody issue?_____________________________

Is your child adopted? ______________When were they told?________________________

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FAMILY INCOME

Does your child work? ☐Yes ☐No Hours: ___________ Position:_______________

Does the family have financial difficulties? ☐Yes ☐No

SCHOOL

School District:_________________________________ School:____________________________

Present Grade:__________ Repeated a grade?______ Present grades?____________________

How does your child feel about school?____

Has your child ever had difficulties with: ☐Math ☐ Reading ☐Language ☐Speech ☐Hearing

____

Has your child ever received special education services? ☐Yes ☐No

Does your child have a current IEP or 504 Plan? ☐Yes ☐No

Have you received complaints or compliments from your child's school about behavior or achievement?
Please explain:____

Has your child ever been afraid to go to school?____

Has your child ever been the victim of bullying?____

BEHAVIOR

Please check any of the following that are typical of your child's behavior:

____Does not feel liked
____Feels lonely
____Shy with children
____Prefers to be alone
____Worries
____Moody
____Sad
____Cries easily
____Expects failure
____Does not share
____Lacks motivation
____Sexual acting out
____Preoccupied with sexual thoughts

____Does not feel like self
____Easy to anger
____Stubborn
____Defiant
Aggressive with:
Peers____
Siblings_____
Adults____
____Needs the last word
____Stealing from home
____Will not admit blame
____Sets fires
____Poorly organized
____Clumsy

____Poor hygiene
____Sleep difficulties
____Sleep walking
____Bedwetting – present
____Bedwetting – past
____Soiling
____Unusual thinking
____Unusual behaviors
____Violent behavior
____Destruction of property
____Not always truthful
____Fails to understand consequences
____Feelings of guilt

____Tics or twitches
____Compulsive behavior
____Talks impulsively
____Takes unnecessary risks
____Short attention span
____Daydreams
____Jealousness
____Acts impulsively
____Overactive
____Perfectionist

Has your child ever used alcohol, tobacco, or drugs? Please specify type, amount, and frequency:____

PERSONAL ADJUSTMENT

How does your child relate to: Mother?__________________Father?________________

Step parent(s)?__________________________Siblings?__________________________

Authority Figures?________________________Peers?____________________________

COUNSELING/PRIOR TREATMENT HISTORY

How does your child feel about counseling?_____________________________________

Has your child had psychotherapy/counseling or attended a support group before? ☐Yes ☐No If yes, please list below:

Name of Center	Type of Service Outpatient/inpatient/Day Treatment	Dates	Drug or Alcohol Treatment (Y/N)

Has your child ever experienced thoughts of harming him/herself or another person? ☐Yes ☐No If yes, please explain:____

Does your child have a history of suicide attempts or harming others? ☐Yes ☐No

If yes, please describe:____

Has your child ever experienced or witnessed trauma, physical or sexual abuse?____________
____

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Is there anything else you would like us know about your child?____________________________

____

Parent or Guardian Signature:____

Date

-For Office Use-

____

Therapist's Signature Date

Based on the information provided above, a physical exam Is Required Is Not Required

M.D./D.O. Comments____

____

____

Physician Signature Date

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