CRYSTAL COUNSELING

PERSONAL HISTORY – MINOR (Child)

Client's Name: ____ Date: ________________

Gender: ___F ___M Race:_________________ Date of Birth: ___/___/______ Age: _____ Grade in School: _____

Form completed by (if someone other than client):_____________________________ Relationship: __________

Address: ____ City: ____________________

Zip:_____________ Check Preferred Phone □(home): ________________ □(work): ________________

□(cell): __________________ Okay to leave messages □Voice □ Text

Emergency Contact: ________________________________ Phone: ______________________________

Relation: ____

Primary reason(s) for seeking services:

____ Anger management	____ Anxiety	____ Self-Harming Behaviors	____Depression
____ Eating disorder	____ Relationship issues	____ Sexual Abuse	____ Fear/phobias
____ Sleeping Disturbance	____ Suicidal Ideations	____School Issues	____ Hyperactivity
____ Self-Esteem	____ Impulse Control	____ Inattentiveness	____ Other concerns

Please explain all checked responses: ____ _______________
____

Duration of above symptoms:____ _________________________
____

Developmental History/ Significant Events: ____

What kind of discipline is used at home when child misbehaves? ____

What are some of your child's weaknesses? ____

____

What are some of your child's strengths? ____

____

CURRENT FAMILY STRESSORS Have any of the following stressful events occurred within the past 12 months?

______ parents divorced or separated	_______ family accident or illness	____ death in family
______ parent changed job	_______ changed schools	____ family moved
______ family financial problems	_______ Other (please specify) ___________________________	

Family History

Client's Mother Name: _____________________ Age: ______Occupation: _____________________ FT: ___ PT:__

Relationship to adolescent: □Natural Parent □Step-parent □Adopted □Foster parent □Other:_______________

Day phone: ___________________ Evening Phone: __________________

Client's Father Name: _____________________ Age: ______ Occupation: _____________________FT: ___ PT:___

Relationship to adolescent: □Natural Parent □Step-parent □Adopted □Foster parent □Other: ______________

Day phone: ___________________ Evening Phone: __________________

With whom does the client live with at this time? ____

Were the client's parents ever married? ___No ___Yes

Are parent's divorced or separated? ___No ___Yes If "Yes", who has legal custody? ____________________

Is there significant information (present of past) about the parents' relationship or treatment toward the child which might be beneficial in counseling? ___No ___Yes If "Yes", please describe:____________________________

____

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of Relationship with the Client
_______________	____	___F ___M	___Home ____Away	___Poor ___Average ___Good
_______________	____	___F ___M	___Home ____Away	___Poor ___Average ___Good
_______________	____	___F ___M	___Home ____Away	___Poor ___Average ___Good
_______________	____	___F ___M	___Home ____Away	___Poor ___Average ___Good

Others Living in the Household	Age	Gender	Relationship (cousin, grandparent, etc.)	Quality of Relationship with the Client
_______________	____	___F ___M	_______________________	___Poor ___Average ___Good
_______________	____	___F ___M	_______________________	___Poor ___Average ___Good
_______________	____	___F ___M	_______________________	___Poor ___Average ___Good

Relationship information that would be beneficial for counseling: ____

____

Family Health History

Have any of the following diseases occurred among the adolescent's blood relatives? (parents, siblings, aunts, uncles, or grandparents) Check those which apply:

□ Allergies
□ Anemia
□ Asthma
□ Bleeding tendency
□ Blindness
□ Cancer
□ Cerebral Palsy
□ Cleft lips/Palate
□ Deafness
□ Diabetes
□ Glandular problems
□ Heart disease
□ High blood pressure
□ Kidney disease
□ Learning disabilities
□ Mental illness
□ Migraines
□ Multiple sclerosis
□ Muscular Dystrophy
□ Nervousness
□ Perceptual motor disorder
□ Mental retardation
□ Seizures
□ Spinal Bifida
□ Substance abuse
□ Suicide
□ Other

Comments and descriptions regarding family health history: ____

____

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Education

Current school: ___________________ Type: ___ Public ___Private ___Home schooled ___Other:_________

Has the client had counseling sessions with their school counselor? ___No ___Yes, currently ___Yes, previously

If "Yes", please describe:

____

____

In special education? ___No ___Yes If Yes, please describe: ____

In gifted program? ___No ___Yes If Yes, please describe:____

Has the client ever been held back in school? ___No ___ Yes If Yes, please describe: ________________________

Has the client ever been suspended: ___No ___Yes If Yes, please describe__________________________________

Have there been recent changes in the client's grades? ___No ___Yes If Yes, please describe:_________________

____

Has client ever attempted or ran away from home or school? ___No ___Yes If Yes, please describe:___________

____

Client Medical / Physical Health

□ Sensory Processing	□ Asthma	□ Blackouts	□ Diabetes
□ Dizziness	□ Heart Trouble	□ Hepatitis	□ Hives
□ Meningitis	□ Unusual Cravings	□ Tics	□ Seizures
□ Severe head injury	□ Thyroid disorder	□ Chronic Ear Infections	□ Other ______________

Please explain all checked: ____

____

List any recent health or physical changes: ____

Please check if there have been any recent changes in the following:

□ Sleep patterns	□ Eating patterns	□ Physical activity level	□ Energy level	□ Mood
□ Behavior	□ Weight	□ General disposition	□ Nervousness	□ Continence

Describe the changes in areas checked above: ____

____

Medications

Currently prescribed medications	Dose	Frequency	Date Started	Purpose	Side Effects
__________________________	________	___________	__________	____________	□No □Yes
__________________________	________	___________	__________	____________	□No □Yes
__________________________	________	___________	__________	____________	□No □Yes
__________________________	________	___________	__________	____________	□No □Yes

Current over-the-counter meds	Dose	Frequency	Date Started	Purpose	Side Effects
__________________________	________	___________	__________	____________	□No □Yes
__________________________	________	___________	__________	____________	□No □Yes

List any medication allergies:

____

CRYSTAL COUNSELING

Therapeutic Goals

What are the guardian goals for the client's therapy? ____

____

____

____

What family involvement would you like to see during the therapeutic process?

____

____

____

Do you believe your child may be suicidal at this time? ___No ___Yes

If Yes, please explain:

____

____

For Staff Use

Therapist's comments:

____

____

Therapist's signature/credentials: ____ Date: _______________

Supervisor's comments:

____

____

Supervisor's signature/credentials: ____ Date: _______________