

Alliance Counseling & Coaching

Channahon - Joliet - Plainfield

HISTORY FOR THERAPY ASSESSMENT

Child/Adolescent

Client Name: _____ Date: _____

Address: _____

City/State/Zip: _____

Home phone: _____ Cell phone: _____

Email: _____

Age: _____ Date of Birth: _____ Gender: _____ Marital Status: _____

Father's Name: _____

Address: _____

Home phone: _____ Cell phone: _____

Mother's Name: _____

Address: _____

Home Phone: _____ Cell phone: _____

Name of legal guardian(s): _____

Address if different from above: _____

Home phone: _____ Cell phone: _____

Is legal guardianship shared? If yes with whom: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone: _____

How did you hear about Alliance Counseling & Coaching?

- | | |
|---|---|
| <input type="checkbox"/> Returning client | <input type="checkbox"/> Family friend |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Google search |
| <input type="checkbox"/> Alliance website | <input type="checkbox"/> Psychology Today |
| <input type="checkbox"/> Dr. Referral | <input type="checkbox"/> Other: _____ |

Work History: (If applicable)

Are you currently employed? Yes No

If so, where? _____

Type of work or career? _____

If employed, do you like your job? _____

Education:

Current grade: _____ Have you ever been held back? Yes No

Issues at school with other students/teachers/performance/behavior?

Presenting Issue for Counseling (why you brought your child in for counseling):

SYMPTOMS/LIFE ISSUES:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Depressed | <input type="checkbox"/> Feel panicky | <input type="checkbox"/> Sexual Acting Out |
| <input type="checkbox"/> Clingy behavior | <input type="checkbox"/> Tiredness | <input type="checkbox"/> Shy | <input type="checkbox"/> Home conditions bad |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Drugs | <input type="checkbox"/> Can't keep job |
| <input type="checkbox"/> Bowel disturbance | <input type="checkbox"/> Can't sleep | <input type="checkbox"/> Anxious | <input type="checkbox"/> Self harm |
| <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Aggression | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Fast Heartbeat | <input type="checkbox"/> Hearing difficulty | <input type="checkbox"/> Overambitious | <input type="checkbox"/> Can't make decisions |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Feel inferior | <input type="checkbox"/> Lonely | <input type="checkbox"/> Bedwetting/soiling |

Do any of the following describe you?

- | | | | |
|---|---------------------------------------|--|---|
| <input type="checkbox"/> Specific fears | <input type="checkbox"/> Tremors | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Lightheadedness |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Doom | <input type="checkbox"/> Agoraphobia | <input type="checkbox"/> Obsessions/Compulsions |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Nervousness | |

If yes, describe how: _____

PREVIOUS MENTAL HEALTH TREATMENT:

Therapist	Location	Dates	Outcome

PSYCHIATRIC HOSPITALIZATION? (List All)

Psychiatric Hospital	Date	Reason for Admission	Length of Stay

Suicidal thoughts: Past Present

Explain: _____

Suicidal attempts:

Method Used: _____ When: _____

Where: _____

How was it stopped: _____

Hospitalization: (Please Explain) _____

Self harming behavior: Past Present

Explain: _____

CURRENT PSYCHIATRIC MEDICATIONS:

Name	Type/Purpose	Dosage	Frequency Taken

History of mental illness in family? Yes/No Please describe _____

CURRENT/PAST MEDICAL OR PHYSICAL PROBLEMS/CONDITIONS:

(Allergies, seizures, high blood pressure, diabetes, cardiac problems TB, etc) _____

Name of Medical Doctor: _____ Phone: _____

Name of Psychiatrist: _____ Phone: _____

Date of last physical exam: _____ Where/Doctor: _____

CURRENT MEDICATIONS, VITAMINS, & OVER THE COUNTER:

Name	Purpose	Dosage	Frequency	Prescribed by

Health Behavior: (Please be specific-Frequency/Amount, Etc.)

Nicotine: _____

Caffeine: _____

Beer: _____

Wine: _____

Liquor: _____

Marijuana: _____

Speed/Downers: _____

Other drugs: _____

Nutrition: Poor Adequate Excellent

If poor, please explain: _____

Exercise: Poor Adequate Excellent

If poor, please explain: _____

Sleep Issues: (night terrors, insomnia, etc.) Yes No

Explain: _____

FAMILY DATA/HISTORY:

	Name	Birth Date	Age	Sex	Living or Dead	Marital Status
Father						
Mother						
Legal Guardian						
Step-Parents						
Siblings						
Step Siblings						

Describe each parent in three words (indicate if step-parent):

Mother _____

Father _____

Which parent are you closest to? _____

Describe past/current relationship with parents:

Describe parent's relationship to each other:

What is your birth order? _____

Describe past/current relationship with siblings: _____

Any history of physical/sexual/emotional abuse? Yes No

Explain: _____

Who is your child's best friend? _____

Do parents approve of their friends? _____

Describe significant life events: _____

Has your child/adolescent lost someone through death?

How did they handle that situation? _____

Sexual History: (If applicable)

Describe your parent's attitudes towards sex:

How did you learn about sex?

Have you had any frightening or unpleasant sexual experiences?

Any abuse or trauma? _____

Number of, if applicable: Pregnancies _____ Miscarriages _____ Abortions _____

Legal:

Any current legal problems? (ie, court order, probation/parole, guardianships, arrest, order of Protection, truancy, DCFS): _____

Additional Information:

Please describe any violent/aggressive behavior and the frequency:

Please list child/adolescent's strengths:

Any other important information your counselor should know about your child or adolescent?

Client signature

(if client is 14 years old or older)

Parent/Legal Guardian signature

(If minor under age 18 years)