CHARIS Counseling Associates
CONFIDENTIAL HISTORY INFORMATION (AGES 0-18)

CLIENT NAME: _____

What has led you to seek counseling or evaluation for your child/adolescent at this time: _____

_____

_____

When did these concerns or struggles develop: _____

Has your child/adolescent ever attempted suicide or made any self-harm attempts: YES NO

If yes, how long ago was the last attempt: _____

Does your child/adolescent have current thoughts of ending his/her life or harming him/herself: YES NO

If yes, what is his/her plan: _____

Does your child/adolescent have current thoughts of harming anyone else: YES NO

If yes, what is his/her plan: _____

Is your child/adolescent currently experiencing overwhelming sadness, grief, or depression? YES NO

If yes, for approximately how long? _____

Is your child/adolescent currently experiencing anxiety, panic attacks, or have any phobias? YES NO

If yes, when did he/she begin experiencing this? _____

What significant life changes or stressful events have you or your child/adolescent experienced recently:

_____

Support System: Who can your child/adolescent count on for support: *(please circle all that apply)*

Parents	Spouse	Significant Other	Self Help Group	Employer	Church
Therapist	Neighbor	Extended Family	Close Friend	Pastor	Siblings
Co-Worker	Medical Doctor	Other: _____			

Symptoms, Specific Concerns or Problem Areas: *(Please circle any that are currently troubling you or your child/adolescent)*

Abortion	Divorce	Legal Matters	Separation
Abuse	Dreams	Loneliness	Sexual Abuse / Rape
Addictions	Drug Use	Loss of Control	Sexual Addiction
Adoption	Eating Disorder	Loss of Trust	Sexual Issues
Alcohol Use	Education	Low Energy	Shyness
Ambition	Energy	Lying	Single parent
Anger / Temper	Envy / Jealousy	Marriage	Singleness
Anxiety	Family Issues	Medication / Drug Issues	Sleep
Apathy	Father Issues	Memories	Spouse / ex-spouse
Appetite	Fear / worry	Moodiness	Stealing
Arguing	Finances / Debt	Mother Issues	Step parent
Attentiveness	Forgiveness	Nervousness	Stomach Problems
Bedwetting	Friends	Nightmares/bad dreams	Stress
Bitterness / Resentment	Fighting	Panic Attacks	Substance Abuse
Burnout	Frustration	Parenting	Suicidal Thoughts
Change in Life	Grief	Poor Concentration	Swearing
Child Rebellion	Guilt	Poor Memory	Thoughts
Communication	Headaches	Pornography	Tiredness
Concentration	Health / Medical	Rejection	Unemployment
Confusion	Hyperactivity	Relaxation	Unhappiness
Crisis	Immaturity	Religion / Spiritual Issues	Violence / Rage
Death	Impulsiveness	Running away	Visitation
Decisions	Inferiority	School	Weight
Depression	Infidelity	Self-Control	Withdrawal
Discipline/Disobedience	In-laws	Self-Esteem	Work

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PREVIOUS COUNSELING OR MENTAL HEALTH TREATMENT

Has your child/adolescent ever been in counseling before? YES NO

Has your child/adolescent ever been hospitalized for a mental health or addiction reason? YES NO

If yes to either of the above questions, please describe it below. Start with most recent time first.

A. When was the counseling or hospitalization? _____

Where did your child go? _____ Name: _____

Explain what happened: _____

_____

What was helpful to your child: _____

B. When was the counseling or hospitalization? _____

Where did your child go? _____ Name: _____

Explain what happened: _____

_____

What was helpful to your child: _____

What are the current prescription medications your child/adolescent is taking?

MEDICATION	DOSE	PRESCRIBING PHYSICIAN
_____	_____	_____
_____	_____	_____
_____	_____	_____

In the past, which psychiatric medications were prescribed for your child/adolescent?

MEDICATION	DOSE	APPROXIMATE DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has a physician ever recommended any anti-anxiety, anti-depressant, ADHD, or anti-psychotic medication for your child?

YES NO *If yes, please describe* _____

GENERAL HEALTH INFORMATION

Height:_____ Weight:_____ Recent weight gain/loss:_____

Last physical exam:_____ Report:_____

Please list your child/adolescent's primary care doctor, address and phone: _____

_____

List any childhood diseases:_____

List any allergies:_____

Any prolonged fever of more than 103 degrees?_____

Convulsions, fainting, breathing problems, or loss of balance:_____

Head injuries:_____

Hospitalizations:_____

How would you rate your child/adolescent's current physical health? *(please circle)*

POOR UNSATISFACTORY SATISFACTORY GOOD VERY GOOD

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CONFIDENTIAL HISTORY INFORMATION (AGES 0-18)

Please circle all current difficulties that your child/adolescent is experiencing:

Accidents	Diarrhea	Hospitalizations	Sleep problems
Allergies	Dizziness	Hypertension	Stomach problems
Anorexia / bulimia	Doesn't like to be touched	Indigestion	Stroke
Arthritis	Dry mouth	Infections	Surgeries
Back injury/pain	Eating patterns	Influenza	Tension
Blackouts	Excessive sweating	Muscle spasms	Thyroid
Blood pressure (high or low)	Fainting spells	Nausea	Tics
Blood sugar (high or low)	Falling	Palpitations	Tingling
Bowel Problems	Fatigue	Pneumonia	Transplants
Burning or itchy skin	Flushes	Poor appetite	Tremors
Cancers	Hair loss	Pregnancy	Twitches
Chest pains	Headaches	Rapid heart rate	Unable to relax
Constipation	Head injury / trauma	Renal problems	Visual disturbances
Chronic pain	Hearing problems	Respiratory problems	Vomiting
Dementia	Heart disease	Sexual problems	Watery eyes
Diabetes	Hormone changes	Skin problems	Weight

Please list any other major health problems or events your child has experienced: _____

_____

Rate your child/adolescent's current sleeping habits *(please circle):*

POOR UNSATISFACTORY SATISFACTORY GOOD VERY GOOD

Please list any specific sleep problems your child/adolescent is currently experiencing: _____

_____

How many times per week does your child/adolescent generally exercise? _____ Types of exercise: _____

DEVELOPMENTAL HISTORY

Is your child adopted? YES NO If so, at what age?_____ Where was your child born?_____

Was the pregnancy planned or unplanned _____

During the pregnancy were there any complications? YES NO (*if so, please describe*):_____

_____

Any difficulties for the mother during the pregnancy? (i.e. blood sugar, excessive weight gain, alcohol or drug use, high blood pressure)

YES NO *(please explain):*_____

How close to the due date was the baby born?_____ Did mother suffer from postpartum depression? YES NO

Birth weight:_____ Length:_____ Head circumference:_____

Length of labor:_____ Normal, breech, or cesarean delivery:_____

Anything unusual such as cord around neck, breathing difficulties, etc.? _____

As a baby, were there any frequent illnesses (i.e. colds, vomiting, diarrhea, dehydration, ear infections)?_____

At approximately what age did your child:

Crawl: _____ Walk alone: _____ Toilet train: _____ Pedal tricycle: _____ Bedwetting: _____ Watch TV: _____ First word: _____

First sentence: _____ Spoke clearly: _____ Skip: _____ Color: _____ Use scissors: _____

Does/did your child/adolescent fear being separated from you?_____

Does your child/adolescent follow instructions from parents?_____

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Please circle all that your child/adolescent has tried or is currently using. *Circle (P) if it was past. Circle (C) if it is current.*

Acid – LSD	P	C	Crack	P	C	Meperidine	P	C	Opiates	P	C
Alcohol	P	C	Dextromethorphan	P	C	Mescaline	P	C	Oxycodone	P	C
Ambien	P	C	Diuretics	P	C	Methadone	P	C	Oxymorphone	P	C
Amphetamines	P	C	Energy drinks/pills	P	C	Methamphetamine	P	C	Salvia divinorum	P	C
Anti-depressant	P	C	Fentanyl	P	C	Methylphenidate	P	C	Soda pop	P	C
Anti-Anxiety	P	C	Flunitrazepam	P	C	Milk	P	C	Sleep mediation	P	C
Barbiturate	P	C	GHB	P	C	Morphine	P	C	Spice	P	C
Benzodiazepines	P	C	Hashish	P	C	Mushrooms	P	C	Sport Drinks	P	C
Caffeine	P	C	Heroin	P	C	MDMA	P	C	Steroids	P	C
Codeine	P	C	Hydrocodone	P	C	Pain Relievers	P	C	Stimulants	P	C
Coffee	P	C	Inhalants	P	C	PCP	P	C	Tea	P	C
Coke	P	C	Ketamine	P	C	Propoxyphene	P	C	Tobacco	P	C
Cocaine	P	C	Marijuana	P	C	Psilocybin	P	C	Water	P	C

PERSONALITY OF CHILD/ADOLESCENT

Client's life in general: *(circle one)* VERY HAPPY HAPPY AVERAGE UNHAPPY VERY UNHAPPY

Client's life in last six months: *(circle one)* VERY HAPPY HAPPY AVERAGE UNHAPPY VERY UNHAPPY

What is your child/adolescent's greatest fear:_____

What is your child/adolescent's greatest hope:_____

Have there been any noticeable changes in behavior or personality at any time in his/her life?_____

_____

How many moves has your family made and what was the age of child/adolescent at each move?_____

_____

Does your child/adolescent ever have hallucinations?_____

Does your child/adolescent ever complain of hearing voices that others do not hear?_____

Please describe any past or current traumas your child has experienced (including abuse, physical, sexual or verbal): _____

_____

Please describe your child's interaction with adults: _____

_____

Please describe your child's interaction with other children: _____

_____

How many of your child's peers can you describe? NONE SOME MOST ALL

Do you like your child's peers? NONE SOME MOST ALL

Have any of your child's friends been in trouble with the law? NONE SOME MOST ALL

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CONFIDENTIAL HISTORY INFORMATION (AGES 0-18)

How would you describe your child/adolescent's personality and/or temperament (happy, content, fussy, quiet, irritable)?

List assigned chores and how well they do them:

Describe the discipline program you use at home:

Do the adults in the home agree on the use of this discipline program?

What does your child/adolescent currently do too often, too much, or at the wrong times, that gets him/her in trouble? Please list all the behaviors you can think of:

What does your child/adolescent fail to do, as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of:

What does your child/adolescent do that you like? What does he/she do that other people like?

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FAMILY OF ORIGIN

Client's parent's marital status: NEVER MARRIED MARRIED SINGLE DIVORCED WIDOWED SEPARATED OTHER:

How would you describe their relationship? EXCELLENT GOOD FAIR POOR N/A

Client's Mother's Name: _____ Age _____ Deceased? YES NO

If yes, cause _____ Child's age at the time of mother's death _____

Client's Father's Name: _____ Age _____ Deceased? YES NO

If yes, cause _____ Child's age at the time of father's death _____

Does your child/adolescent have stepparents? YES NO

List the people who currently live in child/adolescent's household, and how he/she gets along with each one:

Family member	Age	Relationship	Comment

Significant individuals or family members not currently living with the child/adolescent:

Name	Age	Relationship	Comment

What is your child/adolescent's birth order: ___ of ___ children. Who primarily raised him/her? _____

How would you describe their childhood: TRAUMATIC PAINFUL UNEVENTFUL LOVING JOYFUL OTHER *Please explain*:

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If YES, please indicate the family member's relationship to your child/adolescent in the space provided (father, grandmother, brother, uncle, etc.).

Alcohol/Substance Abuse	YES	NO	_____
Anxiety	YES	NO	_____
Attention Deficit	YES	NO	_____
Bipolar Disorder	YES	NO	_____
Depression	YES	NO	_____
Divorce	YES	NO	_____
Domestic Violence	YES	NO	_____
Eating Disorders	YES	NO	_____
Extremely Critical	YES	NO	_____
Hyperactivity	YES	NO	_____
Obesity	YES	NO	_____
Obsessive Compulsive Behavior	YES	NO	_____
Over Controlling	YES	NO	_____
Poverty	YES	NO	_____
Schizophrenia	YES	NO	_____
Suicide Attempts	YES	NO	_____

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PARENT'S OCCUPATION

Are you (the parent/guardian) currently employed? YES NO FULL TIME PART TIME

If yes, employer and occupation? _____

_____

How long employed or unemployed? _____

Is the child/adolescent's other parent/guardian currently employed? YES NO FULL TIME PART TIME

If yes, employer and occupation? _____

_____

How long employed or unemployed? _____

Your combined current approximate household income $ _____ per _____

LEGAL HISTORY

Is your child/adolescent currently on probation or parole? YES NO (*If yes, please explain)*: _____

_____

Has your child/adolescent ever been involved in domestic violence? YES NO (*If yes, please explain)*: _____

_____

Is your child/adolescent currently involved in a legal matter? (including custody) YES NO (*If yes, please explain)*: _____

_____

SCHOOL HISTORY

Name of school child/adolescent is attending:_____

Grade:_____ Average grade point:_____

Has your child/adolescent's behavior ever been of concern to his/her teachers? YES NO (*If yes, please explain)*: _____

_____

Does your child/adolescent have any difficulties learning? YES NO (*If yes, please explain)*: _____

_____

Does your child/adolescent have any difficulty in writing (i.e. reversals, poor coordination, letters, etc.)? YES NO (*If yes, please explain):* _____

Does your child/adolescent have any difficulty with reading or arithmetic? YES NO (*If yes, please explain)*: _____

_____

What extracurricular activities is your child/adolescent involved in? _____

What are your child/adolescent's strengths in school?_____

ELECTRONIC USE

How many hours does your child/adolescent spend online daily? *(circle)* 0-2 2-4 4-6 6-8 8 or more

How many hours does your child/adolescent spend daily watching TV or movies? 0-2 2-4 4-6 6-8 8 or more

How many hours does your child spend daily playing video or computer games? 0-2 2-4 4-6 6-8 8 or more

How often do you find that your child/adolescent stays online longer than you intended?

DAILY WEEKLY MONTHLY INFREQUENTLY NEVER

How often do others in his/her life complain to your child/adolescent about the amount of time he/she spends online?

DAILY WEEKLY MONTHLY INFREQUENTLY NEVER

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SPIRITUAL AND CULTURAL

Which best describes your (underline) and your child/adolescent's (circle) spiritual beliefs or worldview:

Agnostic	Hinduism	Nonreligious	Spiritual but unaffiliated
Atheist	Islam	Unitarian Universalism	Taoism
Christian	Jainism	Rastafarianism	Tenrikyo
Baha'i	Juche	Sikhism	Zoroastrianism
Buddhism	Judaism	Shinto	Other:
Cao Dai	Neo-Paganism	Spiritism	

How would you rate your child/adolescent's spiritual or religious experiences on a scale of 1-5 *(please circle rating):*

very harmful 1 2 3 4 5 very helpful

Would your child/adolescent like to discuss God in counseling sessions? _____

Would your child/adolescent like to pray in counseling sessions? _____

Describe your cultural/racial background: _____

_____

How would you rate your child/adolescent's cultural/racial experiences on a scale of 1-5 *(please circle rating):*

very harmful 1 2 3 4 5 very helpful

Please list any concerns, which may have affected you or your child/adolescent, in regard to spiritual or cultural experience:

_____

_____

PERSONAL

What are some of your child/adolescent's strengths? _____

_____

_____

What are some of your child/adolescent's weaknesses? _____

_____

_____

What does your child/adolescent consider to be his/her main passions and interests? _____

_____

_____

What would you like to accomplish as a result of your child/adolescent's time in therapy?

_____

_____

Please list any concerns you may have about your child/adolescent beginning counseling:

_____

_____

_____ _____

Signature of individual giving this report Date