COMPASS COUNSELING WAUSAU, LLC
CHILD/ADOLESCENT PERSONAL HISTORY
Ages 4 – 17 Years

NAME: ____ AGE ____ DOB_____________

Address ______________________________ City ______________ State ___ Zip ___________

Phone Number __________________________ Cell Number__________________________

What is the problem or concern your child is being seen for?

____

____

____

MEDICAL HISTORY:
Name of Physician:____

Last seen by physician and reason: ____

Please list medical problems/hospitalizations: ____

____

____

Has your child ever experienced a head injury, seizures, loss of consciousness? Yes____ No____
If yes, please state

____

____

Pregnancy and delivery issues ____

____

Did mother use alcohol or drugs during pregnancy? _____No _____ Yes, please list

____

Did child meet all developmental milestones on time? _____Yes _____No, please explain

____

Medications (including supplements):____

____

____

PAST MENTAL HEALTH TREATMENT: (counseling, hospitalizations, past medications)

____

____

____

Has your child experienced abuse in the past or present? Yes____ No____
Verbal____ Physical____ Sexual____ Emotional neglect____ Domestic violence ____
Please explain ____

____

How would you describe your child? Circle as many descriptions as appropriate.

Happy	Calm	Overly emotional	Angry	Sad	Rebellious
Finicky	Bright	Confident	Spoiled	Lonely	Withdrawn
Fearful	Sensitive	Very active	Crabby	Shy	Explosive

What are your child's strengths?

____

____

EDUCATION:
Name of School ____

Does your child have a disability and or an IEP? _____No_____Yes

If yes, explain ____

Please list any problems child is experiencing in school

____

____

Mother's Name ____

Address ____

Home Phone ______________________

Employer ____________________________ Occupation ____________________________

Work Phone ______________________________

Father's Name ____

Address ____

Home Phone ______________________

Employer ____________________________ Occupation ____________________________

Work Phone ______________________________

Stepmother's Name ____

Address ____

Home Phone _______________________

Employer _______________________________ Occupation ____________________________

Work Phone ______________________________

Stepfather's Name ____

Address ____

Home Phone _______________________

Employer ______________________________ Occupation _____________________________

Work Phone ______________________________

Has the child ever lived with anyone other than parents (foster care, relatives, etc)? ___No ___Yes

If yes, whom?____

Any special family circumstances you would like us to be aware of?

____

____

What kind of discipline is used with your child?

____

____

Does child have any legal involvement or Social Service involvement? _____No _____Yes,

Explain: ____

____

____

Names of Siblings/Stepsiblings:	**Age:**	**Live with child:**
_________________________________	_____	_____________
_________________________________	_____	_____________
_________________________________	_____	_____________
_________________________________	_____	_____________
_________________________________	_____	_____________
_________________________________	_____	_____________
_________________________________	_____	_____________

DURING THE PAST FOUR WEEKS, HAS YOUR CHILD EXPERIENCED ANY OF THE FOLLOWING?

If child is over 12 years of age – please have him/her complete checklist.

Nearly Daily	Sometimes	Not Really	
______	______	______	Trouble remembering things
______	______	______	Spells of sudden fear that did not make sense
______	______	______	Trouble doing your school work
______	______	______	Thoughts of dying
______	______	______	Clinginess
______	______	______	Being in too many arguments
______	______	______	Avoiding things/places, people, activities
______	______	______	Feeling keyed up or on edge
______	______	______	Having peculiar or strange thoughts
______	______	______	Worry
______	______	______	Feelings of guilt
______	______	______	Sad Mood
______	______	______	Irritability, easily annoyed
______	______	______	Poor concentration
______	______	______	Sleep problems
______	______	______	Change in appetite/not eating/throwing up after eating
______	______	______	Low energy or feeling tired
______	______	______	Headaches, pains
______	______	______	Shortness of breath, chest pains
______	______	______	Dizziness, numbness, trembling
______	______	______	Voiding of urine in bed or clothes
______	______	______	Passes feces into clothes or other inappropriate places
______	______	______	Suck fingers, twirls hair, etc to comfort self
______	______	______	Tearful
______	______	______	Outbursts of anger
______	______	______	Being bullied
______	______	______	Problems with friends/peers
______	______	______	Problems with adults
______	______	______	Not liking self
______	______	______	Self-injury behaviors
______	______	______	Alcohol or drug use

The space below is yours to use for any comments, questions, or requests you would like to bring to the therapist's attention, including goals for treatment at Compass:

____

____

____

______________________________ ______________________________

Signature of Parent/Guardian Date