COMPASS COUNSELING WAUSAU, LLC
CHILD/ADOLESCENT PERSONAL HISTORY
Ages 0 – 17 Years

IMPORTANT

Failure to answer all questions may result in the delay of appointment scheduling. If a question does not apply, write N/A. If you do not know the answer, write DO NOT KNOW.
NOTE: The information you provide is confidential and protected by law.

Name _____ Age _____ DOB_____
Address _____ City _____ State _____ Zip _____
What are your hopes and goals for your child through this experience: _____
_____

EDUCATION:
Name of School: _____ Grade: _____
School Clubs/ apart of: _____
What type of grades: A B C D F Favorite Subject: _____ Least Favorite: _____
Learning Disabilities___ Yes ___ No If yes, please explain: _____
Does your child have an IEP or 504 plan? If yes, please explain: _____
_____
Has your child ever been suspended or expelled from school? If yes, please explain: _____
_____
Does your child attend daycare or before/ after school care? If so, where: _____
How long have they been in attendance? _____ Frequency: _____

EMPLOYMENT:
Does client have a full or part time job? _____Yes _____ No
If yes, where do they work? _____ How long have they been working there? _____

What concerns bring you/ your child here today? (Check those that apply)

If child is 12 or over, please have them complete chart:

Behavior Concerns:

___ Self- injury behavior
___ Physical aggression
___ Verbal aggression
___ Lying/ stealing
___ Trouble making friends
___ Trouble keeping friends
___ Head banging
___ Hair twirling/ pulling
___ Alcohol/ drug use
___ Struggles socializing
___ Withdrawn
___ Clingy
___ Child is a loner
___ Tearful
___ Perfectionist
___ Refusal to attend school
___ Rage
___ Talks back
___ Swears at people, things, situations
___ Nightmare
___ Sexually acting out
___ Other _____

Emotional Distress:

___ Depression/ Sadness
___ Anger
___ Moodiness
___ Anxiety
___ Suicidal/ homicidal
___ Psychotic- like symptoms
___ Death
___ Parent divorce
___ Other _____

Functional Concerns:

___ Poor Hygiene
___ Problems with mobility
___Problems with hearing
___ Problems with speech
___ Recognition of danger
___ Money management
___ Safety problems
___ Employment
___ High or low energy
___ Irresponsible
___ Physical pain/ injury
___ Impulse control
___ Social relationships
___ Sleep problems
___ Eating problems
___ Sensory problems
___ Poor grades
___ Memory problems
___ Learning problems
___ Cognitive problems
___ Problems with play
___ Concentration problems
___ Unmotivated
___ Lack of coordination
___ Fine motor problems
___ Feeding aversion
___ Difficulty chewing/ swallowing

MEDICAL HISTORY:

Name of physician: _____ Last seen by physician: _____
Reason: _____
Known allergies: _____

Please list currently prescribed medications:

Medication	Dose	Frequency	Prescribing Physician
1.			
2.			
3.			
4.			

EATING:
___ No Problems
___Drooling ___ Food falls from mouth ___ Texture sensitivity ___ Gags ___Eats limited type of food
___ Increase/ Decrease in appetite- Since: _____ Obsessed with food- Since: _____
___ Weight gain/ loss- Since: _____ How much: _____

CURRENT SLEEP:
___Duration in hours ____Requires naps ____ Midnight awakening ____Early awakening ___ Difficulty falling asleep
___ Nightmares ___ Frequency: ___ per week ___ Content: _____
Was the child attached to any inanimate object (i.e. blanket, teddy bear, etc.)? ___ Yes ___No
If yes, what object? _____ From age: _____ to _____.

SIGNIFICANT TRAUMA: (Include age at time of incident, nature of trauma and any legal details)
___ Injured in an accident: _____
___ Physical abuse (Child was the ____ Victim ___ Perpetrator): _____
___ Sexual abuse (Child was the ____ Victim ___ Perpetrator): _____
___ Emotional abuse (Child was the ____ Victim ___ Perpetrator): _____
___ Neglect: _____
___ Removed from home _____ Foster care____ Residential treatment
___ Parent or others removed from the home. If yes, please explain: _____
___ Coping with divorce: ___ Yes ___No If yes, please explain: _____
___ Head injuries or loss of consciousness. If yes, how many times: _____ Last time occurred: _____
___ Seizures. If yes, frequency: _____ Length of time they last: _____ Occurring for how long: _____
___ Pregnancy & delivery complications. If yes, explain: _____
___ Alcohol or drug use during pregnancy. If yes, explain: _____
___ Delays in meeting developmental milestones on time? _____ Yes _____ No, please explain: _____
_____

MENTAL HEALTH HISTORY:
Has your child ever been in counseling in the past? ____ No ____ Yes

Clinician/ Therapist Name	**Dates Seen**	**Reason for visits**
1.		
2.		
3.		

Has your child ever been hospitalized for psychiatric reasons? ___ No ___ Yes
If yes, please explain: _____
_____
Has your child ever thought about committing suicide? ___ No ___ Yes. If yes, when? _____
Has your child ever attempted to commit suicide? ___ No ___ Yes. If yes, when? _____

FAMILY INFORMATION:
Mother's Name _____ Phone _____
Address _____ Lives with: Yes____ No ____

Employer _____ Occupation _____ Work Phone _____
Parenting Style: Firm, Loose, Laid- back, Yells, Avoids, Fun, Hovers, Harsh, talks too much, conflictual, calm
Father's Name _____ Phone _____
Address _____ Lives with: Yes____ No ____
Employer _____ Occupation _____ Work Phone _____
Parenting Style: Firm, Loose, Laid- back, Yells, Avoids, Fun, Hovers, Harsh, talks too much, conflictual, calm
Stepmother's Name _____ Phone _____
Address _____ Lives with: Yes____ No ____
Employer _____ Occupation _____ Work Phone _____
Parenting Style: Firm, Loose, Laid- back, Yells, Avoids, Fun, Hovers, Harsh, talks too much, conflictual, calm
Stepfather's Name _____ Phone _____
Address _____ Lives with: Yes____ No ____
Employer _____ Occupation _____ Work Phone _____
Parenting Style: Firm, Loose, Laid- back, Yells, Avoids, Fun, Hovers, Harsh, talks too much, conflictual, calm

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

_____

_____

Has the child ever lived with anyone other than parents (foster care, relatives, etc.)? ___ Yes ___No
Please Explain: _____
Was this during the first three years of life? ___ Yes ___ No
Please Explain: _____

Names of Siblings	Living in the Home		Date of Birth	Full or Step Sibling	Quality of Relationship		
	Yes	No			Good	Fair	Poor
	Yes	No			Good	Fair	Poor
	Yes	No			Good	Fair	Poor
	Yes	No			Good	Fair	Poor
	Yes	No			Good	Fair	Poor

Others Living in Household	DOB	Relationship to Child	Quality of Relationship		
			Good	Fair	Poor
			Good	Fair	Poor
			Good	Fair	Poor
			Good	Fair	Poor

Other Important People in the Child's Life:	DOB	Relationship to Child	Quality of Relationship		
			Good	Fair	Poor
			Good	Fair	Poor
			Good	Fair	Poor
			Good	Fair	Poor

DISCIPLINE:
Physical ____ Spanking ___ Other _____
Non- physical ___ Time outs ___ Yelling ___ Taking things away ___ Praise ___ Other
Please explain _____

	Immediate Family	**Maternal Family**	**Paternal Family**

Mark an 'X' in all appropriate boxes.	Bio- Mother	Bio- Father	Step- Parent	Brother	Sister	Grandmother	Grandfather	Step-	Uncles	Aunts	Grandmother	Grandfather	Step-	Uncles	Aunts
Attention Difficulties															
Learning Difficulties															
School Problems															
Behavior Problems															
Depression															
Anxiety															
PTSD															
Drug/ Alcohol Abuse															
Legal Issues															
Hallucinations/ Delusions															
Bipolar															
Eating Disorder															
Epilepsy															
Mental Retardation															
Dementia, Alzheimer's															
Traumatic Brain Injury															
Autism, Asperger's															
Heart or Lung Problems															
Speech/ Language Problem															
Genetic Disorder															
Cancer															
Diabetes															
Early Death															
Suicide/ Attempted Suicide															

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 Counseling, LLC:

_____

_____

_____ _____

Signature of Parent/Guardian Date

AODA Information: (To be filled out if applicable)

Check if ever used	Name of Chemical (Circle the applicable substance)	How much	How Often	Durations	Method	Age of First Use	Age of Last Use
	Beer, Wine, Liquor						
	Marijuana/ Hashish						

	Amphetamines, Speed, uppers, Ritalin, Dexedrine, Meth, Crank, Ephedrine						
	Cocaine, Crack, Rock						
	Inhalants, (glue, aerosols, Glade, etc) LSD, PCP						
	Mushrooms, Peyote						
	Heroin						
	Opium, Morphine, Codeine						
	Methadone						
	Pain Killers (Darvon, Midol)						
	Nonbarbiturates: Restoril, Unis, sleeping pills						
	Barbiturates: Amytal, Luminol, Seconal, Nemputal, downers						
	Antianxiety Agents: Valium, Librium, Ativan						
	Antipsychotic Agents: Mellaril, Risperidol						
	Antidepressants						
	Designer drugs: Cat, Special K, Ecstasy						
	Tobacco, chew						
	Vaping, juuling						
	Other:						

Has your child ever experienced blackouts or memory loss? ___ No ___Yes
If yes, please explain: _____
_____

Does your child feel alcohol or drugs cause problems for them? ___No ___Yes
If yes, please explain: _____
_____

Has your child's family, friends or employer ever objected to their drinking or drug use? ___ No ___Yes
If yes, please explain: _____
_____

Has your child ever attempted to cut down or stop drinking or using drugs? ___ No ___ Yes
If yes, please explain: _____
_____

Does your child have any sexually transmitted or communicable diseases? ___No ___ Yes
If yes, please explain: _____

Has your child ever been arrested: ___ No ___ Yes
If yes, please explain: _____
_____