Alliance Counseling & Coaching

Channahon – Joliet – Morris

HISTORY FOR THERAPY ASSESSMENT

Child/Adolescent

IDENTIFYING INFORMATION:

Client:

Name: _____ Date: _____

Address: _____

City/State/Zip: _____

Home phone: _____ Cell phone: _____

Age: _____ Date of Birth: _____ Gender: _____

Email: _____

Mark preferred method of contact, may choose more than one

___When contacted, do not mention agency name ___Text Message
___Phone ___Email Additional Email_____

- **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: _____

Insurance Policy Holder:

Name: _____ Date of Birth: _____

Address: _____

Home phone: _____ Cell phone: _____

Social Security Number: _____

*****Please put an "X" in the box next to the party responsible for balance.**

Emergency Contact:

Name: _____Relationship: _____

Home phone: _____ Cell phone: _____

How did you hear about Alliance Counseling & Coaching?

Internet Phone book Doctor Friend Other: _____

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

_____

SYMPTOMS/LIFE ISSUES:

___Headaches	___Depressed	___Feel panicky	___Sexual Acting Out
___Clingy behavior	___Tiredness	___Shy	___Home conditions bad
___Vision problems	___Nightmares	___Can't make decisions	___Can't keep job
___Bowel disturbance	___Can't sleep	___Anxious	___Self harm
___Stomach trouble	___Fainting spells	___Aggression	___Alcoholism
___Fast Heartbeat	___Hearing difficulty	___Overambitious	___Drugs
___Dizziness	___Feel inferior	___Lonely	___Bedwetting/soiling

PREVIOUS MENTAL HEALTH TREATMENT:

Therapist	Location	Dates	Outcome

PSYCHIATRIC HOSPITILIZATION? (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?_____

Hospitilization?_____

Please Explain:_____

Self harming behavior: Past? Present? Expalin:_____

CURRENT PSYCHIATRIC MEDICATIONS:

Name	Type/Purpose	Dosage Taken	Frequency Taken

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

_____

CURRENT/PAST MEDICAL OR PHYSICAL PROBLEMS/CONDITIONS:(i.e. 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 Taken	Frequency Taken	Prescribed by

Health Behavior (Be specific, No. of ounces, etc.):

Nicotine_____ Caffeine_____Beer_____Wine _____

Liquor_____Marijuana_____Speed/Downers_____Other drugs_____

Prescription medications: _____

Nutrition ⬜ Poor ⬜ Adequate ⬜ Excellent If poor, please explain_____

Exercise ⬜ Poor ⬜ Adequate ⬜ Excellent If poor, please explain_____

Sleep issues? (night terrors, insomnia, etc.) _____

FAMILY DATA/HISTORY:

	Name	***Birth date***	***Age***	***Sex***	***Living or Dead***	***Marital Status***
FATHER						
MOTHER						
LEGAL GUARDIAN						
STEP PARENTS (if applicable)						
BROTHERS and/or SISTERS						

OTHERS: (Stepbrother & Sisters)						

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? No/Yes, please explain _____

_____

Who is child's best friend? _____

Do parents approve of their friends? _____

Describe significant life events _____

_____

Has 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? _____

Any frightening or unpleasant sexual experiences? _____

Any abuse or trauma? _____

Number of, if applicable: Pregnancies _____ Miscarriages_____ Abortions_____

Work History: (If applicable)

Are you currently employed? _____ If so, where? _____

Type of work? _____

If employed, do you like your job? _____

Education

Current grade _____ Ever been held back?_____

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

_____

Legal

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

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/adolescent?

_____

_____

_____

Client signature (if client is 14 years old or older) _____

Parent/Legal Guardian signature _____

(If minor under age 18 years)

Date _____