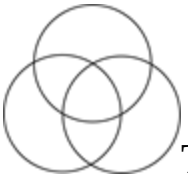


Trilogy Counseling Services

Child/Adolescent History Form

Please provide the following to help us understand your child's living situation.

Child's Last Name_____First_____

Date of BIrth_____Age_____Gender_____Language_____

Lives with_____Relationship_____

Primary Address_____City_____

Home Phone_____Cell Phone_____Work Phone_____

Parent Name_____Age_____

Address same as above or_____City_____Zip_____

Home Phone_____Cell Phone_____Work Phone_____

Marital Status (circle) single married divorced separated widowed cohabitating other

Parent has (circle all) primary custody joint custody primary placement shared placement other

Other members of the household (list)_____

Parent Name_____Age_____

Address same as above or_____City_____Zip_____

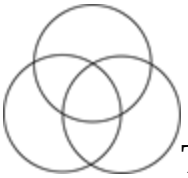
Home Phone_____Cell Phone_____Work Phone_____

Marital Status (circle) single married divorced separated widowed cohabitating other

Parent has (circle all) primary custody joint custody primary placement shared placement other

Other members of the household (list)_____

Sibling – Names	Sex	Age	Type (Bio, Step, Half, Etc.)	Living Situation



Trilogy Counseling Services

Instructions: Please provide the following information to assist us in best helping your child and family.

Child's Name_____Today's Date_____

Name of Parent/Guardian completing form:_____

What problem is your child having that concerns you?

_____

_____

_____

_____

When did the problem start?

_____

Has the child ever received mental health treatment? If so, When and by whom?

_____

Has the child ever taken medication for emotional or behavioral problems? If so, what, when and by whom?_____

_____

What do you see as your child's strengths?

_____

_____

In the past month, what has been your child's biggest success or accomplishment?

_____

_____

Who does your child look to for help and support?

_____

_____

What are your family's strengths?

_____

_____

Who do you as a parent rely on for support and assistance?

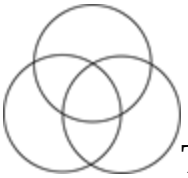
_____

_____

Is your child receiving any other special help or therapies?

_____

_____



Trilogy Counseling Services

Medical History

Please answer the following questions regarding your pregnancy and delivery with this child:

Pregnancy Mother was healthy

Mother had health problems

Mother smoked Used alcohol Used drugs

Violence toward mother during pregnancy

Delivery Full term Premature at _____months Adopted at _____ of age

List any medical complications_____

Extended hospital stay for Infant and/or Mother

Has your child had a history of medical problems?

(Describe)_____

_____

_____

Have there been significant hospitalizations, operations, procedures or injuries?

(Describe)_____

_____

_____

Are there current medical problems or concerns?

(Describe)_____

_____

_____

Is the child currently taking medication? (List medication and prescribing physician)

_____

_____

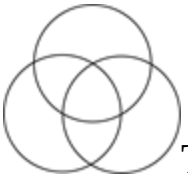
_____

Name of child's primary care physican/pediatrician:_____

Address_____Phone_____

Has your child seen the Primary Care Physician/Pediatrician within the past year? Yes No

Below is a list of developmental concerns or problems. Check (X) all that apply to your child.



Trilogy Counseling Services

Description	At what age(s)	Current Status (Describe)
Slow to crawl		
Slow to walk		
Slow to talk		
Not like being touched or held		
Difficulty toilet training/bedwetting/soiling		
Problems with sleep		
Problems with eating		
Easily upset/hard to calm down		
Not like being around people		
Too active for child's age		
Low energy		
Physical disability		
Learning problems		
Other		

School

Name_____Address_____

Teacher_____Grade_____Phone Number_____

Does your child have an IEP? No Yes for_____

Childcare

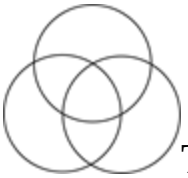
Name_____Address_____

Contact person_____Phone Number_____

Other Program

Name_____Address_____

Contact person_____Phone number_____



Trilogy Counseling Services

Below is a list of experiences that some children have had to deal with. Check (X) all that apply to your child.

	Teasing or bullying by another		Physical abuse
	Conflict in family		Sexual Abuse
	Separation of parent(s)		Emotional or verbal abuse
	Frequent moves in location		Witnessing violence at home
	Divorce		Witnessing violence in the community
	Medical emergency or difficult procedure		A hurricane, flood, tornado or other bad storm
	Death or loss of someone close		Car crash or other serious accident
	Medical problem of parent		Family member victim of crime
	Emotional problems of parent		Other event that extremely upset or bothered child
	Drug/alcohol problem of parent		Describe
	Foster care		

What would you like to see change for your child as a result of treatment? For yourself as a parent?

_____
_____
_____
_____

Thank you for providing this information.