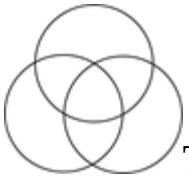


Trilogy Counseling Services

Child/Adolescent History Form

Client Name:_____

Date of Birth:_____**Age:**_____**Gender:**_____**Language:**_____

Lives with:_____**Relationship:**_____

Primary Address:_____**City:**_____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

Parent Name:_____**Age:**_____

Address:_____**City**_____**Zip**_____

Home Phone:_____**Cell Phone:**_____**Work Phone:**_____

Marital Status:

Single / Married / Divorced / Separated / Widowed / Cohabitating / Other

Parent has (circle all):

Primary Custody / Joint Custody / Primary Placement / Shared Placement / Other

Parent Name:_____**Age:**_____

Address:_____**City:**_____**Zip:**_____

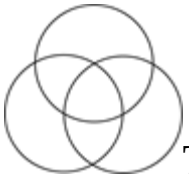
Home Phone:_____**Cell Phone:**_____**Work Phone:**_____

Marital Status:

Single / Married / Divorced / Separated / Widowed / Cohabitating / Other

Parent has (circle all):

Primary Custody / Joint Custody / Primary Placement / Shared Placement / Other



Trilogy Counseling Services

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

What problem(s) is your child having that concern(s) you?

_____

_____

_____

When did the problem start?

_____

_____

_____

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

_____

_____

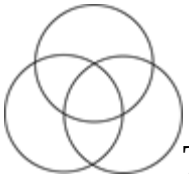
_____

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

_____

_____

_____



Trilogy Counseling Services

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?

_____

_____

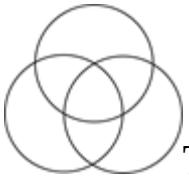
_____

Is your child receiving any other special help or therapies?

_____

_____

_____



Trilogy Counseling Services

Medical History

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 / mother

Has your child had a history of medical problems?

_____

_____

_____

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

_____

_____

_____

Are there current medical problems or concerns?

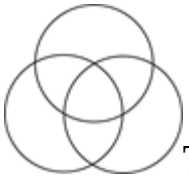
_____

_____

_____

Is the child currently taking medication?

_____



Trilogy Counseling Services

Name of child's PCP/GP:_____

Address:_____Phone:_____

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

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		

Trilogy Counseling Services

School History

Name:_____Address:_____

Teacher:_____Grade:_____Phone_____

Number:_____

Does your child have an IEP/504? Yes No

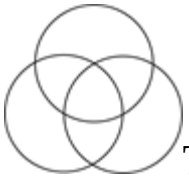
Childcare History

Name:_____Address:_____

Contact Person:_____Phone:_____

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		



Trilogy Counseling Services

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.