Christian Counseling Centers of Oregon
Personal History Inventory
~Child~

Please fill out this form and bring it with you to your first session. All provided information will be protected as a confidential document.

*****In working with children, it is my policy that the parent/guardian remains on the premises of the therapist's office building during the child's session. This allows me to involve you in your child's counseling session, when appropriate, and it is for the safety and best interest of your child.*

Contact Information

Child's Name: _____ Birth date: _____ Age: _____

Parent/Guardian: _____

Current Address: _____

Apartment or Box #:_____ City: _____ State:_____ Zip:_____

Home Phone: _____ Is it ok to leave a message? Yes [ ] No [ ]

Cell/Other Phone: _____ Is it ok to leave a message? Yes [ ] No [ ]

Email: _____ Is it ok to e-mail you? Yes [ ] No [ ]

What is your preferred way for me to contact you? _____

Emergency Contact Name*: _____ Phone: _____

*This person will only be contacted in case of an emergency. By giving their contact information, you are authorizing me to break confidentiality of our relationship.

Referred by (if any):_____

Current

Please describe your reasons for seeking counseling for your child at this time:

How long have these issues been of concern to you?

What do you hope to happen by bringing your child to counseling?

Family of Origin
Please list names/ages of any immediate family members that are still living (father, mother, siblings, step parents, step siblings):

Please describe any major life transitions or traumas your child has experienced either recently or in the past. Please include dates and the child's age when it occurred.

Please circle any of the following that your child's family members currently battle. Please identify their relationship to the child (i.e. mother, brother, aunt, grandparent etc.)

Alcohol/Substance Abuse
Anxiety
Bipolar
Depression
Domestic Violence
Eating Disorders
Obesity
Obsessive Compulsive Behavior
Schizophrenia
Suicide Attempts
Other:

Social
Is your child involved with any social groups, churches, activities, hobbies, sports teams, etc.?

How does your child act within social settings?

Does your child have any close relationships? Yes [ ] No [ ] If yes, please describe:

Education
In what grade is your child currently enrolled?

Has your child experienced any problems at school?

Has your child ever been diagnosed with a learning disability? If so, please explain:

General Health
Current Physician: _____ Phone: _____

List all medications (prescription and psychiatric) including the dosage and strength:

How would you describe your child's physical health?

Have there been any changes in your child's current sleeping habits? Yes [ ] No [ ] If yes, please describe.

Have there been any changes in your child's daily eating habits? Yes [ ] No [ ] If yes, please describe.

Are you aware if your child drinks alcohol? Yes [ ] No [ ] If yes, please describe.

Are you aware if your child engages in recreational drug use? Yes [ ] No [ ] If yes, please describe.

Any other medical concerns I should be aware of?

Mental Health
Has your child ever met with a counselor before? Yes [ ] No [ ] If yes, please describe this experience.

Has your child ever attempted suicide? Yes [ ] No [ ] If yes, describe the situation.

Please indicate your child's general mood level over the last month by circling a number below:

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
suicidal depressed down average happy ecstatic

Please indicate your child's current level of anxiety over the last month by circling a number below:

1 2 3 4 5 6 7 8 9 10
peaceful uneasy worried panicky

Spiritual
Is your child exposed to spiritual/religious beliefs? Yes [ ] No [ ] If yes, please give a brief description.

Has your child found their spiritual beliefs to be helpful or a hindrance?

Personal
How would you describe your child's personality?

What would you define as your child's greatest strengths?