`

HOPE AND RESTORATION PATHWAYS CHRISTIAN COUNSELING, INC

CHILD/ADOLESCENT CONFIDENTIAL HISTORY AND INFORMATION

Please note: for simplicity, the term "child" is utilized to reference both a child and an adolescent.

Please complete this history carefully and as completely as possible. Your therapist/counselor will utilize this information in establishing a plan of care for your child.

Identifying Information:

Child/Adolescent Name: _____ M ___ F___

Date of Birth: _____ Age: _____

If parents are divorced, and a rotating custody schedule exists, where and when does your child live, if not full time at a single residence?

_____

_____

Grade in school: _____ School: _____

Parent's marital status:

____married ____engaged ____ single parent household

___/___ separated/length of time ____/____ divorced/length of time

____ unmarried parents in one household ____ unmarried parents in different households

Religious Preference: _____ Does your family attend church, and if so, what activities does your child participate in?

_____

Parents or Caregivers:

Natural Father:

Name: _____ Age ___ Living Y N
Address: _____

`

Health of parent (circle): Excellent Good Fair Poor Terminal Illness
Parent health concerns that may impact child:_____
If deceased, cause of death _____
Occupation: _____ Status: Part-time Full-time

Natural Mother:

Name: _____ Age ___ Living Y N
Address: _____
Health of parent (circle): Excellent Good Fair Poor Terminal Illness
Parent health concerns that may impact child:_____
If deceased, cause of death _____
Occupation: _____ Status: Part-time Full-time

Alternative Caregivers:

If not living with any of the above natural parents, please indicate the alternative family arrangement, such as adoptive, step-parent, foster, or grandparents:

Type of alternative caregiver or parent: ___ Adoptive ___ Step-parent
___ Foster ___ Grandparent ___ Other (_____)

Name: _____ Age ___ Living Y N
Address: _____
Health of caregiver (circle): Excellent Good Fair Poor Terminal Illness
Parent health concerns that may impact child:_____
If deceased, cause of death _____
Occupation: _____ Status: Part-time Full-time

Presenting Problems:

What is the primary concern that has led you to seek counseling for your child?

_____
_____
_____

When did this problem begin?_____

What have you done thus far in attempting to resolve this concern?_____
_____

`

Please list all professionals and agencies involved thus far in the problem:_____
_____

Home Environment or History of Trauma:

Are there any stressors in the household, family life, or parental relationship that may impact your child?

_____
_____
_____
_____

Is there any history of abuse or trauma that may have some relationship to any of the problems that your child may be experiencing?

_____
_____
_____
_____

Are any of these concerns present?

(check any that apply) _____ Frequent family conflict _____ Parental neglect or abuse of child _____ Parental Mental Illness _____ Parental conflict
_____ Parental substance abuse _____ Any history of abuse or neglect
_____ Sibling conflict or rivalry

Please describe in detail:

_____
_____
_____
_____
_____

`

Desired Outcomes of Counseling:

What do parents see as needing to change as a result of intervention?

(Please check any that apply):

____ child's attitude ____ child's fears/worries ____ parent-child relationship ____ improvement in child's behavior ____ child's grades ____ interaction with others at school ____ sleep schedule _____ family relationships ____ sibling relationships ____ co-parenting challenges, if not residing with both natural parents ____ Other specific desired counseling outcomes:

_____
_____
_____
_____
_____

Does your child have difficulties with school or peers at school? Y N

_____
_____
_____

Legal Problems

Has the child been in trouble with the law or involved with the court system in any way? Y N If yes, please give details:

_____
_____

Is there any legal action pending or considered, including custody considerations? Y N If yes, please give details:

_____
_____
_____
_____
_____

`

Medical Information

Did the child's mother have any problems during pregnancy or delivery? Y N
If yes, please explain:

_____

Is your child on any medication? Y N If yes, please list all medications taken:

Name of Medication: _____ *Reason:* _____ *Prescriber:*_____

Name of Medication: _____ *Reason:* _____ *Prescriber:*_____

Name of Medication: _____ *Reason:* _____ *Prescriber:*_____

Family Structure

List all persons living in the household or households if a co-parenting arrangement is in place where the child lives between two parents:

Name/Relationship Age Location Occupation/Grade

_____
_____
_____
_____
_____
_____
_____

Additional Concerns to Address in Counseling:

Are there any other concerns that you desire to become a focus of counseling or that you would like the therapist/counselor to address in sessions regarding your child?_____
_____
_____
_____
_____

Thank you for providing this valuable information regarding your concerns relating to your child or adolescent. We understand that sharing this private information is very difficult, but we want to reassure you that this information will be treated with the highest level of confidentiality. Having this information will greatly assist your clinician in the provision of quality treatment in order to address these concerns adequately.