Child/Adolescent Personal History

Please take your time and complete this entire form. The information you give us will help us understand you better and identify all the services that may be helpful to you.

Current Date: ______________________________
Client Name: ______________________________ Date of Birth: ________________
Person Completing Form: ______________________
Address 1: ____
Telephone Number(s): Home: (____) __________ Cell: (____) __________ Work: (____) ______
Address 2: ____
Telephone Number(s): Home: (____) __________ Cell: (____) __________ Work: (____) ______
Address 3: ____
Telephone Number(s): Home: (____) __________ Cell: (____) __________ Work: (____) ______

May we contact you and leave a message at: House Number: ☐ Yes ☐ No Cell: ☐ Yes ☐ No Work: ☐ Yes ☐ No
May we text you on your cell phone? ☐ Yes ☐ No
May we text you appointment reminders on your cell phone? ☐ Yes ☐ No
In order of preference, with 1 being most preferred, please indicate which number you prefer we call you:
Home:__________ Cell:__________ Work:______________
Email Address: ______________________ Is it ok for us to contact you at this email: ☐ Yes ☐ No

Emergency Contacts:
Contact #1: Name: ______________________ Telephone Number: (____) ______________________
Relationship to Client: ______________________
Contact #2: Name: ______________________ Telephone Number: (____) ______________________
Relationship to Client: ______________________

Why are you seeking help for this child? ____
____
What would life look like for your child/family when treatment is completed or when goals are accomplished from JFS? ______
____
____

Please check the items that affect your child:

☐ Worries	☐ Lies Frequently	☐ Weight Loss	☐ Bedwetting
☐ Crying Spells/Sadness	☐ Steals	☐ Overweight	☐ Gang Involvement
☐ Moody	☐ Sets Fires	☐ Often Ill	☐ Guilt/Shame
☐ Expects Failure	☐ Bizarre Behavior	☐ Unusual Thinking	☐ Gender Concerns
☐ Lazy/Unmotivated	☐ Angry, Defiant	☐ Blinking, Jerking	☐ Destructive
☐ Avoids Adults	☐ Frequent Daydreams	☐ Sleepwalking	☐ Suicide Gestures
☐ Speech Problems	☐ Short Attention Span	☐ Bullies	☐ Cutting/Self Harm
☐ Soiling	☐ Sexual Acting Out	☐ Police Problems	☐ Pinning Away
☐ Temper Tantrums	☐ Messy	☐ Poor Appetite	☐ Quarrels
☐ Careless, Reckless, Impulsive	☐ Increased Alcohol Use Or Drug Use	☐ Difficulty Sleeping/Waking	☐ Learning Problems
☐ Gender Orientation Concerns	☐ Is Easily Overstimulated In Play	☐ Short Attention Span	☐ Lacks Self-Control
☐ Seems Unhappy Most of the Time	☐ Withholds Affections	☐ Hides Feelings	☐ Has Fears
☐ Seems Overly Energetic in Play	☐ Seems Impulsive	☐ Cannot Calm Down	☐ Requires a lot of Parental Attention
☐ Overreacts when Faced with a Problem	☐ Seems Uncomfortable Meeting New People	Other: ______________________	

Revised: 1/2015; 4/2016; 12/2016; 5/2017; 6/13/2017; 8/7/17; 9/20/17

Jewish Family Service OF METRO DETROIT

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Self-Harm Assessment and History

Does your child have any thoughts now or recently of wishing he/she were dead? ☐ Yes ☐ No
Has your child ever attempted suicide or tried to harm his or herself? ☐ Yes ☐ No
If yes, when: ____
Please explain circumstances (how, why?): ____
Has anyone in your family attempted or died by suicide? ☐ Yes ☐ No
If yes, who? ____
Please explain: ____
Has your child ever attempted to kill or seriously harm someone else? ☐ Yes ☐ No If yes, who? ______________________
Please explain: ____

Trauma History

Are you aware of or do you suspect your child/adolescent has experienced or witnessed any of the following:
Please check all that apply:

☐ Flood
☐ Serious Accident
☐ Fire
☐ Incarcerated Family Member
☐ Assault/Physical Abuse
☐ Other: ________________
☐ High Level of Conflict
☐ Exposure to Domestic Violence
☐ Dysfunctional Family Dynamics
☐ Sudden/Unexpected Death of Close Friends/Family
☐ Family History of Mental Health Issues
☐ Serious Medical Issues
☐ Emotional Abuse
☐ Family History of Substance and/or Alcohol Use
☐ Sexual abuse or exposure

Treatment History

Has your child seen a therapist or counselor for mental health treatment? ☐ Yes ☐ No
If yes, when? ______________________ Where? ______________________
Reason: ____

Has this child ever had a psychological or psychiatric exam? ☐ Yes ☐ No
If yes, when? ______________________ Where? ______________________
Reason: ____

Has your child been in the hospital or residential treatment for mental health or alcohol/drug problems? ☐ Yes ☐ No
If yes, when? ______________________ Where? ______________________
Reason: ____

Were any of these treatment experiences helpful for your child? ☐ Yes ☐ No
Please explain: ____
____

Have any family members been hospitalized for mental health or alcohol/drug problems? ______________________
____

Describe any cultural factors which might affect services i.e. religious observance, ethnicity, socioeconomic factors, immigration factors, etc.: ____
____

Describe any special accommodations which are needed i.e. language, visual or hearing impairments, etc.: ______________________
____

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Child's Family and History

Parents

Mother's Name: ________________________________ ________________ Stepmother: ☐ Yes ☐ No
Address: ____ Age: __________
Home Phone: ______________________________ Work Phone: ____________________________
Father's Name: ________________________________ ________________ Stepfather: ☐ Yes ☐ No
Address: ____ Age: __________
Home Phone: ______________________________ Work Phone: ____________________________

Primary Caregivers

With what adults does the child live: ☐ Custodial Parent(s) ☐ Step-parent ☐ Other: ____________________
How long has the child been in current living situation? ____

Child Care

If primary caregivers work outside the home, please provide the following information:
Who cares for the child when primary caregivers are gone? ____
How many hours per day is this child in a child-care setting? ____
How many different people care for this child? (please explain) ____

Child's Family

Individual	Name	Age	Sex (M/F)	Education	Employment	Marital Status
Father						
Mother						
Sibling (s)						
Others in Home						

Child/Adolescent Personal History

Family History/Relations

Is this child closer to one parent than the other? ☐ Yes ☐ No If yes, which? ______________________

Has this child ever experienced any parental separations, divorces, or death? ☐ Yes ☐ No
If yes, when? ______________________ How old was this child at this time? ______________
Please describe the circumstances: ____

What activities does the child participate in with the family?
☐ Games ☐ Meals ☐ Conversations ☐ Visits with Relatives ☐ Religious Activities ☐ Trips ☐ Movies/TV
☐Other: ______________________

What do you enjoy most about your child? ______________________________________

What do you find most difficult about raising your child? ______________________________

Who is mainly in charge of discipline at home? ______________________________________

Do all caregivers agree on discipline? ______________________________________

Describe discipline strategies or techniques. ______________________________________

Education

Preschool and Daycare

Does this child attend preschool/daycare or have they in the past? ☐ Yes ☐ No At what age? ____________
How many days per week? ______________________________________

Did the child experience any problems in preschool/daycare? ☐ Yes ☐ No
If yes, please describe: ______________________________________

Does this child attend Kindergarten or have they in the past? ☐ Yes ☐ No
Did the child experience any problems in Kindergarten? ☐ Yes ☐ No
If yes, please describe: ______________________________________

Elementary/High School

Has the child changed schools for any other reason than academic advancement? ☐ Yes ☐ No
If yes, please explain? ______________________________________

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Has the child been retained a grade? ☐ Yes ☐ No
If yes, please explain: ____
____

Has the child skipped a grade? ☐ Yes ☐ No
If yes, please explain: ____
____

Does the child have difficulty with reading? ☐ Yes ☐ No
If yes, please explain: ____
____

Does the child have difficulty with math? ☐ Yes ☐ No
If yes, please explain: ____
____

Does the child get poor grades? ☐ Yes ☐ No
If yes, please explain: ____
____

Has the child ever been tested for Special Education? ☐ Yes ☐ No
If yes, when? ____
____

Has the child been placed or is currently placed in a Special Education class? ☐ Yes ☐ No
If yes, please explain what type of class and hours per day: ______________________
____

Does the child dislike going to school? ☐ Yes ☐ No
If yes, please explain: ____
____

Is the child absent from school frequently? ☐ Yes ☐ No
If yes, please explain: ____
____

If the child is in high school, will the child graduate? ☐ Yes ☐ No
If no, please explain: ____
____

Do you have any concerns about the child's school or teachers? ☐ Yes ☐ No
If yes, please explain: ____
____

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Child/Adolescent Personal History

Legal Information

Has the child ever been involved with the legal, police or juvenile court system? ☐ Yes ☐ No

If yes, please explain: ______________________________

Are parents involved in a divorce/custody issue? ☐ Yes ☐ No

If yes, please explain: ______________________________

If parents are separated or divorced, who has custody of this child or do you have joint legal custody?

____

How often does the other parent see the child? Check one:

☐ Weekly or More Often ☐ Once or Twice a Month ☐ Few Times a Year ☐ Never

Was your child adopted? ☐ Yes ☐ No If yes, at what age? __________ If yes, does your child know? ☐ Yes ☐ No

Developmental History

During pregnancy: ☐ Any bleeding ☐ High blood pressure

Check any that were used during pregnancy: ☐ Tobacco ☐ Alcohol ☐ Drugs

Please explain: ______________________________

Did mother have any sickness/difficulties? ______________________________

Birth: ☐ Full term ☐ Premature- weight ____________

Type of delivery: ☐ Normal ☐ Breach ☐ Cesarean

Condition of child at birth? ______________________________

Was child breastfed? ☐ Yes ☐ No If yes, when weaned? ______________________

Was child bottle-fed? ☐ Yes ☐ No If yes, when weaned? ______________________

Was there any concerns with the child bonding to their caregiver?

At what age was child toilet trained? Days: __________________ Nights: __________________

Did bed wetting occur after toilet training? ☐ Yes ☐ No If yes, until what age? ______________

Did bed soiling occur after toilet training? ☐ Yes ☐ No If yes, until what age? ______________

Was there any medical reason for bed-wetting or bed-soling? ☐ Yes ☐ No If yes, please explain: __________________

____

Were there any issues with the following? Check all that apply.

☐ Walking Alone	☐ Unclear Speech	☐ Riding A Bike	☐ Underweight Problems
☐ Colic	☐ Sleep Problems	☐ Vision Problems	☐ Hearing Problems
☐ Motor Skills	☐ Failure To Thrive	☐ Excessive Crying	☐ Feeding/Eating Problems
☐ Overweight Problems	☐ Parental Separation	☐ Other: ______________________	

Friendships/Personal Hobbies

Please indicate how your child relates to other children:

☐ Problems Relating To Other Kids ☐ Fights Frequently With Playmates ☐ Prefers Playing With Younger Children

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☐ Prefers To Play Alone ☐ Plays with Children in the Neighborhood ☐ Has Difficulty Making Friends

Has your child had problems relating to or playing with other children? ☐ Yes ☐ No
If yes, please describe? ____________________

What role does your child take in group games with friends (i.e., leader, follower, etc.)? ____________________

Has the child's interest in participation in these activities declined recently? ☐ Yes ☐ No
If yes, please describe? ____________________

Do your child's friends use illegal substances? ☐ Yes ☐ No If yes, please explain: ____________________

Please indicate if your child engages in any of the following?

☐ Smokes Cigarettes ☐ Chews Tobacco ☐ Drinks Alcoholic Beverages
☐ Uses Illegal Drugs i.e. cocaine, marijuana ☐ Inhales Toxic Substances i.e. paint ☐ Vaping
☐ Hookah

Medical History

Childhood Illnesses/Injuries

Please check all that apply:

☐ Measles ☐ Asthma ☐ Whooping Cough ☐ Frequent Rashes
☐ Mumps ☐ Tuberculosis ☐ Scarlet Fever ☐ Head Injury
☐ Chicken Pox ☐ Anemia ☐ Bruises Easily ☐ Coma/Loss Of Consciousness
☐ Other: ____________________

Other Illnesses/Injuries or Concerns

Please check all that apply:

☐ Seizures/Convulsions ☐ Bangs Head ☐ Accident Prone ☐ Urination in Pants/Bed
☐ Sucks Thumb ☐ Grinds Teeth ☐ Has Tics/Twitches ☐ Bowel Movements in Pants/Bed
☐ Bites Nails ☐ Speech Defects ☐ Stuttering ☐ Unclear Speech
☐ Stomach Pain ☐ Excessive Vomiting ☐ Diarrhea ☐ Constipation
☐ Rocks Back and Forth ☐ Poor Posture ☐ Clumsy Walk ☐ Other Muscle Problems
☐ Ear Infections ☐ Hearing Problems ☐ Vision Problems ☐ Ear Tubes
☐ Other: ____________________

Has this child ever taken medication to increase activity? ☐ Yes ☐ No If yes, when? ____________________
What medication? ____________________

Has this child ever taken tranquilizing medication? ☐ Yes ☐ No If yes, when? ____________________
What medication? ____________________

Has this child ever taken medication for ADD, ADHD or similar problems? ☐ Yes ☐ No If yes, when? ____________________
What medication? ____________________

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Allergies

Does the child have allergies to:

Medicine: ☐ Yes ☐ No If yes, please explain ______________________________

Food: ☐ Yes ☐ No If yes, please explain ______________________________

Other: Please explain ______________________________

Medical Care

Child's Physician: ______________________ Phone Number: ______________________

Address: ______________________ City: ______________ State: ________ Zip: __________

Do you have health insurance? ☐ Yes ☐ No

If no, would you like to talk with a Health Insurance Enrollment Specialist? ☐ Yes ☐ No

If yes, what is the insurance carrier? ______________________________

How often does the child see a PHCP? ______________ Date of Last Visit: ______________

Is the child currently on medication? ☐ Yes ☐ No

If yes, what medication and reason? ______________________________

Client signature: ______________________________ **Date:** ______________

Jewish Family Service Staff Signature: ______________________ **Date:** ______________