SOLID GROUND COUNSELING

Plymouth and South Lyon locations

PERSONAL HISTORY INFORMATION (CHILD / ADOLESCENT)

Welcome to Solid Ground Counseling! Date:_____

The purpose of this form is to get a better understanding of your background and presenting issues. Please note that this information is confidential and, within all legal limits, will not be shared with others.

Child/Adolescent Name:_____ Social Security Number:_____

Address, City, State, Zip:_____

Age: _____ Gender:_____ Date of Birth:_____

Email:_____@_____ Home Phone:_____

Cell Phone:_____ Work Phone:_____

May we leave a message at these #'s? _____

Mother's Name:_____ Preferred method of contact:_____

Address (if different):_____

Father's Name:_____ Preferred method of contact:_____

Address (if different):_____

How were you referred to Solid Ground Counseling? _____

EMERGENCY CONTACT:

Name:_____ Relationship to client:_____

Contact Number: _____ Alternative Number:_____

Address (Street, City, State, Zip): _____

Do you have a personal representative, counselor, guardian, or representative payee? _____

If yes, please indicate the type of relationship and their contact information below:

Circle all that apply: Personal Representative Conservator Guardian

Name: _____ Phone Number:_____

Address (Street, City, State, Zip): _____

TREATMENT INFORMATION:

Person completing form:_____ Relationship to child/adolescent:_____

Reason child / adolescent are coming for treatment: _____

_____

Have your child / adolescent received treatment in the past? _____Yes _____No

If yes, please explain: _____

_____

How does your child / adolescent feel about treatment at this time?_____

_____

What would you like to have happen while your child / adolescent are in treatment here?_____

_____

_____

If needed, are you willing to participate in services that would help in your child's / adolescent's treatment? _____

_____

SCHOOL ADJUSTMENT:

Name of school: _____ Current Grade: _____

Address and Telephone Number: _____

Homeroom / Primary Teacher's Name: _____

Has a grade ever been repeated? If yes, which one? _____

What kind of grades are your child / adolescent receiving? _____

Please describe any difficulties your child / adolescent are experiencing in school: _____

_____

_____

_____

How would you describe your child's / adolescent's intellectual functioning?

_____ Good _____ Fair _____ Poor

Has your child / adolescent ever been psychologically tested? If yes, please explain:_____

_____

Have your child / adolescent ever received special education? If yes, please explain:_____

_____

PERSONAL ADJUSTMENT

Please check ALL of the following that are typical for your child / adolescent's behavior:

Shy_____	Angry, Defiant_____	Slow moving_____
Worries_____	Quarrels_____	Difficult sleep_____
Moody_____	Bullies_____	Sleepwalking_____
Sad, cries often_____	Temper tantrums_____	Bedwetting_____
Loner_____	Lies frequently_____	Soiling_____
Expects failure_____	Destructive_____	Poor appetite_____
Selfish_____	Steals_____	Weight loss_____
Lazy_____	Sets fires_____	Overweight_____
Avoids conflict_____	Drug/alcohol_____	Often ill_____
Sexual trouble_____	Frequent headaches_____	Unusual thinking_____
Police problems_____	Stomach aches_____	Bizarre behavior_____
Tics or twitches_____	Messy_____	Blinking, jerking_____
Easygoing_____	Careless, reckless_____	Seizures_____
Friendly_____	Short attention span_____	Speech problems_____
Enthusiastic_____	Frequent day dreams_____	Learning problems_____
Confident_____	Acts without thinking_____	Cooperative_____
Overactive_____	Sloppy hygiene_____	Generous_____
Clumsy_____	Frequent injuries_____	Suicide gestures_____
Suicide attempt_____	Psychiatric problems_____	

Please use this space to explain any of the above items: _____

_____

_____

_____

_____

LEGAL ISSUES

Has the child / adolescent ever been involved with the police or juvenile court system? If yes, please explain:

_____

_____

Are both parents in agreement with bringing the child / adolescent into treatment? _____

Are the parents currently involved in a divorce or custody issue? If yes, please explain: _____

_____

Are the parents still married? If no, who has physical and legal custody of the child / adolescent?_____

_____

Does Solid Ground have a copy of the custody agreement? (required) _____ Yes _____ No

CHILD'S / AOLESCENT'S FAMILY

Is your child / adolescent's immunization current? _____ Yes _____ No

	Name	Age	Sex	Employment / Education	Marital status	Closeness of Relationship
Father						
Mother						
Sibling(s)						
Others in the home						

INCOME DATA

Do both parents work? _____ Yes _____ No

Are there any financial problems? _____ Yes _____ No

SOCIAL HISTORY

How does your child / adolescent relate to peers? _____

_____

Has your child / adolescent ever worked? If yes, where? _____

_____

Describe how your child / adolescent relates to adults? _____

_____

With whom does your child socialize? _____

_____

Does your child isolate him/herself from others? If yes, explain: _____

_____

RELIGIOUS INFORMAITON

Does the child / adolescent ascribe to a religion? If yes, please list: _____

Is your child / adolescent affiliated with a church currently? _____

Name of Church: _____ City: _____

As the parent or guardian, were you affiliated with a church as a child / adolescent? If yes, please list the name and address of the church: _____

_____

Would you like prayer incorporated in therapy sessions? _____

CULTURAL / ETHNIC INFORMATION

What cultural or ethnic group are you associated with? _____

Does your child / adolescent closely identify with this group? _____

What strengths has he or she acquired from this identity? _____

_____

_____

DEVELOPMENTAL HISTORY – (check all that apply)

During pregnancy: _____ any bleeding _____ high blood pressure

Used during pregnancy: _____ tobacco _____ alcohol _____ drugs _____ medication

Birth: _____ full term _____ premature _____ late

Please provide additional detail for any checked areas: _____

_____

_____

Did the mother experience any illnesses? If yes, which ones? _____

_____

Other difficulties? _____

Baby's weight at birth: _____ Type of delivery (breech, cesarean, vaginal): _____

Baby's condition at birth? Was oxygen provided? _____

_____

At what age did your child: _____ walk alone _____ use single words _____ sentences _____ toilet train

Has your child / adolescent had a hearing exam and if so, what were the results? _____

_____

Has your child / adolescent had an eye exam, and if so, what were the results? _____

_____

Has your child / adolescent ever had convulsion? If yes, please explain: _____

_____

Please explain any injuries and/or hospitalizations your child / adolescent has experienced: _____

_____

_____

Was your child / adolescent adopted? If yes, at what age? _____ Yes _____ No Age _____

Does your child know they are adopted? _____ Yes _____ No

Please provide any additional information you may have regarding the biological parents and/or family:_____

_____

_____

For girls only: Age at onset of menstrual period: _____ Any problems? _____

_____

Pregnancies: _____ Abortions: _____

Please provide further information if applicable: _____

_____

CHILD'S / ADOLESCENT'S PHYSICIAN INFORMAITON

Physician Name:_____ Contact Number:_____

Address: _____

Date and results of last physical exam: _____

_____

Is your child currently taking any medications? If yes, please list and explain what they are for: _____

_____

_____ _____

Parent / Legal Guardian Signature Date

_____ _____

Therapist's Signature & Credentials Date