



Alpha
Psychological
Services, P.C.

PERSONAL HISTORY INFORMATION

Child Form

Name _____ Age _____ Date _____

Address _____ City _____ Zip Code _____

Home Phone) _____ (Parent work #) _____

(Cell) _____

Family History

Father

Mother

Name _____

Ages _____

Highest grade level _____

If deceased, dates _____

Where do they live? _____

If divorced/deceased, has either/both remarried? _____

Step Parent(s) name(s) _____

Brothers/Sisters Names Age Sex Grade Where living Deceased?

Religious History

Do you attend a church? _____ Name of church _____

Family religious background? _____

Legal History

Do you have any legal cases pending? _____

Are you on probation? _____ If yes, court district _____

Personal History

Have you ever been a victim of: ___sexual abuse ___physical abuse ___verbal/emotional abuse

Who was the abuser(s) _____

Has the child ever abused anyone? _____

Social History

How many close friends does the have? _____

How well does the child get along with classmates? _____

What does the child like to do socially? _____

Education

Highest grade achieved _____ Name of school _____

Employment (if applicable)

Current employer _____

Been here for _____ years

Duties _____

Medical History

Physician _____ City _____

Last seen (approx date) _____ for _____

Taking any prescription medication?

For _____ Medication _____ Dosage _____ Since _____

For _____ Medication _____ Dosage _____ Since _____

For _____ Medication _____ Dosage _____ Since _____

Side effects? _____

Any on-going medical conditions? _____

Previous Mental Health Treatment

Has the child seen a counselor before? _____ How long ago? _____

Location _____ How many sessions? _____

At that time, sought treatment for? _____

Any other family members in counseling? _____

Substance Abuse/Drug

Has the child used drugs/alcohol in the past week? ___ Past month? ___

Type _____ Amount _____

Has alcohol/drug use ever caused a problem? _____

Please explain _____

Has the child ever been treated (residential/out patient) for substance abuse? _____

Where and when _____

Parents or grandparents with alcohol/addiction problems? _____

Siblings with alcohol/drug/addiction problems? _____

Daily Routine

How well does the child sleep? _____

Fall asleep OK? ___ Stay asleep? _____

Feel rested in AM? _____

Any changes in last six months? _____

How is the child's appetite? _____

Any changes in last six months? _____

Weight loss in last year? _____ Gain? _____

Energy level during the day? _____

Does the child currently have any homicidal thoughts? _____

Does the child currently have any suicidal thoughts? _____

Anything else you feel would be helpful for your counselor to know? (If additional space is needed, please use reverse side of this sheet.)

Signature: _____ Date: _____