CLIENT CHILD/TEEN BACKGROUND HISTORY FORM

[PsychSolutions, Inc]

PRENATAL / EARLY DEVELOPMENT:

1. How was their mother's health during **pregnancy**? Excellent / Good / Poor (please explain)_____

2. Circle any of the following consumed during pregnancy? Cigarettes / alcohol / drugs /Other

3. Any complications during pregnancy?_____induction? C-section? _____
   What was their birth weight?_____/ Birth health? Excellent / Good / Poor (please explain)_____

4. Overall, as a toddler, how would you describe their temperament? very difficult / difficult / avg / easy

5. Indicate the age at which your child developed the following **skills**: Crawling_____Walking_____
   First words_____Toilet training_____Getting dressed without help_____Riding a bike _____
   Ability to complete simple chores independently _____

6. Please circle any difficulties your child had during the first three years of life.
   Poor eye contact / didn't get along well with peers / overly fearful/ colicky/irritable / difficulty adjusting to schedules (eating/sleeping, etc.) / difficult to comfort / sleep problems / resisted affection from others / overactive / threw tantrums / resisted changes in schedule / accident prone / stubborn

HEALTH AND SOCIAL INFORMATION

1. Is your child currently receiving psychiatric services or professional counseling elsewhere? □ Yes □ No
   Have they in the past? □No □Yes Previous therapist's name: _____
   Have they ever been hospitalized for psychiatric reasons? □ Yes □ No
   Have they ever received a psychiatric/psychological diagnosis? □ Yes □No _____

2. Are they currently **suicidal**? □ Yes □ No
   Have they had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never
   Have they had them in the past? □ Frequently □ Sometimes □ Rarely □ Never
   Have they had any previous attempts?_____When? _____
   Do they know anyone who has had suicidal thoughts, attempts, or died by suicide? □ No □ Yes Who?_____

3. Are they currently taking prescribed **medication**? □Yes □No Please list: _____
   If No, have they been previously prescribed psychiatric medication? □Yes □No _____

4. How is their **physical health** at present? Poor / Unsatisfactory / Satisfactory / Good / Very good

5. Please circle any persistent physical symptoms or **health concerns** they have:

Respiratory problems	Headaches	Hypertension
Eye pain/problems	Blood pressure	Diabetes
Previous or Current concussions	Brain Injury	Heart conditions
Neurological Impairments (i.e., Epilepsy)	Chronic pain	Tics

   Other concerns?_____

6. Are they having any problems with their **sleep** habits? □ No □ Yes Check if apply: □ Frequent waking □ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams □ Other

7. Are they having any difficulty with **appetite** or eating habits? □ No □ Yes
   Check if apply: □ Eating less □ Eating more □ Binging □ Restricting
   Have they experienced significant **weight** change in the last 2 months? □ No □ Yes

8. Are they/their partner **pregnant**? □Yes □No /Previous pregnancies? □Yes □No /Miscarriages? □Yes □No

9. How many times per week do they **exercise**?_____Approximately how long each time? _____

10. Do they regularly use **alcohol**? □ No □ Yes How often?_____/week _____/month
    In a typical month, how often do you think they have 4 or more drinks in a 24-hour period? _____

11. How often do they engage in recreational **drug** use? □ Daily □ Weekly □ Monthly □ Rarely □ Never
    If they do, which ones? _____
    Have they had any social problems as a result of their alcohol or drug use? □ No □Yes _____
    Have they ever had legal issues due to their alcohol of drug use? □ No □ Yes _____

12. Are they currently in a romantic **relationship**? □ No □ Yes How long? _____
    From 1-10, how would you rate the quality of their relationship Now?____/10 on Average?____/10

13. Do they have **friends**? □ No □ Yes / Close friends? □ No □ Yes
    How would you rate the quality if their friendships? _____
    Any concerns with **bullying**? □ No □Yes _____

14. In the last year, have they experienced any **significant life changes, stressors, or traumatic events** considered upsetting, embarrassing, shameful, distressing, or scary? Any Rejection? Abandonment? Change of schools? Move? Loss of friends? Loss of health? School failure? Family discord/fighting? Exposure to sexual acts/internet porn? □ No □ Yes _____

15. Please circle any that have happened to your child.

Motor vehicle accident	Had a major illness
Had any work / sports injuries	Had a disturbing medical experience
Been assaulted	Had near drowning incidents
Been hospitalized / had surgeries	

16. Have they ever experienced any of the following? Please circle the relevant ones.

Extreme depressed mood	Panic Attacks	Wild Mood Swings
Phobias	Rapid Speech	Sleep Disturbances
Extreme Anxiety	Hallucinations	Unexplained losses of time
Homicidal Thoughts	Unexplained memory lapses	Suicide Attempt
Alcohol/Substance Abuse	Frequent Body Complaints	Eating Disorder
Body Image Problems	Unexplained feelings/sensations	Unexplained voices
Flashbacks	Feeling detached from yourself	Feeling detached from the world
Feeling unreal	Feeling like in a dreamlike state	Bedwetting
Temper Tantrums	School Refusal	

17. Have they ever experienced any form of **abuse**? □ No□ Yes Is this abuse ongoing? □ No □ Yes
Physical / Sexual / Financial / Mental/ Other

18. Please circle all symptoms your child has experienced (within the last 6 months) and/or find troublesome or disturbing:

Anxiety	Anger / Rage	Depression
Panic attacks	Guilt	Numbness
Easily startled	Shame	Helplessness
Fearfulness	Grief / Loss	Hopelessness
Irritability	Phobia_____	Fatigue / Low energy
Loss of control	Low self esteem	Feeling stressed out
Hyperactivity	Abrupt mood swings	Feeling spaced out
Forgetfulness	Suicidal thoughts	Feeling outside your body
Trembling /Ideation/ Body Shakes	Feeling things are not real	Restlessness
Obsessive thoughts / Behaviors	Thinking "This Is Not Me"	Sleeping Problems
Inability to focus / Concentrate	Nausea	Headaches / Migraines
Nightmares	Change in appetite	Stomach Aches
Flashbacks	Clenching of jaw	Chronic pain
Dizziness / Fainting	Memory loss	Shortness of Breath

FAMILY HISTORY:

1. Has anyone in their family (either immediate family members or relatives) experienced difficulties with the following? (Circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty	Fam Member	Difficulty	Fam Member
Depression	_____	Eating Disorders	_____
Bipolar Disorder	_____	Schizophrenia	_____
Anxiety Disorders	_____	Trauma History	_____
Panic Attacks	_____	Suicide Attempts	_____
Learning Disabilities	_____	Tourette Syndrome	_____
ADD / ADHD	_____	Criminal Misconduct	_____
Autism / Asperger's	_____	Common Disabilities	_____
Obsessive Compulsive	_____	Alcohol/Substance	_____
Abuse	_____		

2. What form of **discipline** have they experienced? What happens when they get into trouble?

_____

_____

_____

3. Have they experienced any separations from their primary care givers? Parental divorce? Remarriage? Hospitalizations?

4. Who are they **closest to**?_____ Feel safest with? _____
Who do they feel **least close** too?_____ Least safe with? _____

ACADEMIC HISTORY:

1. Current School Name?_____Current grade? _____
2. Did they ever skip a grade or were they held back? □ No □Yes _____
3. How would you describe their school experience? _____
4. Do they get along with their teachers/like them? □ No □ Yes _____
5. Any behavioral concerns? □ No □ Yes _____
6. Any learning difficulties? □ No □Yes _____
7. Do they have friends at school? □ No □Yes _____
8. Any previous evaluations or assessments? □ No □Yes _____
9. Any previous or current IPP? □ No □Yes _____

OCCUPATIONAL INFORMATION:

1. Are they currently **employed**? □ No □ Yes
   If yes, who is their current employer/position? _____
   If yes, are they happy at your current position? _____
2. Please list any work-related stressors, if any: _____

LEGAL INFORMATION

1. Do they have any current legal concerns? □ No □ Yes
2. Upcoming trial testimony or legal disposition □ No □Yes
3. Past legal concerns? □ No □ Yes

RELIGIOUS/SPIRITUAL INFORMATION:

1. Do they consider themselves to be spiritual? □ No □ Yes
   Are they religious? □ No □ Yes. If yes, what is their faith? _____
2. Did they previously follow another faith? □ No □ Yes. If yes, which one? _____

SUPPORT / COPING / OTHER INFORMATION

1. What are their effective **coping** strategies? _____
2. Who can they **call on** between sessions if they are in distress? _____
3. What do you consider to be their **strengths**? _____
4. What do they **like most** about themselves? _____
5. What do you **like most** about them? _____
6. What are your **goals** for therapy? _____
7. What are their **goals** for therapy? _____

LIFE EVENTS CHECKLIST

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally, (b) you *witnessed it* happen to someone else, (c) you *learned about it* happening to someone close to you, (d) you're *not sure* if it fits, or (e) it *doesn't apply* to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	*Happened to me*	*Witnessed it*	*Learned about it*	*Not Sure*	*Doesn't apply*
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					