

Lazaro Counseling Center, LLC

Confidential Child/Adolescent History

Please print legibly

Name: _____ DOB: _____ Age: _____ Sex: _____ Today's date: _____

Place of Birth: _____ Grade: _____ School: _____

Information supplied by: _____ Relationship: _____

What is your main concern with your child or adolescent? _____

How long has this problem persisted? _____

What have you done to resolve this problem? _____

My child lives with: _____

Are biological parents: married, separated, divorced (please circle). If divorced, how old was the child at that time? _____

Child's Name	Sex	Age	Lives with	Biological/ step/adoptive

Are there any other family members living with you? _____

Briefly describe the style of parenting used in the household: _____

Has either parent or the child ever been investigated or interview by CPS and/or the police? Yes or No.

Has your child or adolescent ever been hospitalized for any reasons? Yes or No

If so, when, where, and for how long? _____

Has your child ever had any serious illness or surgeries? _____

Does your child take any medications? Yes or No. If so, who prescribes the medication? _____

What are the medications and what is the dosage? _____

How long has your child been taking them? _____

Has your child taken any psychiatric medications in the past, if yes, what were they? _____

To your knowledge, has your child ever talked about wanting to hurt him/herself? If so, when and how often? _____

Has your child ever tried to harm him/herself? If so, how? _____

Does your child have any medical problems? If yes, what? _____

Has your child ever been hospitalized or had any surgeries? (list dates and reason for hospitalization or surgery): _____

Has your child ever had significant weight changes? Yes or No Any more than 10 lbs. in one year? Yes or No

How do they feel about their weight or size? _____

Please check any symptoms or behaviors that your child displays now or in the past

√	Symptom	Past	Present	√	Symptom	Past	Present	√	Symptom	past	present
	Frequent Headaches				Excessive Sweating				Depression		
	Sleeping problems				Drug / alcohol use				Asthma		
	Vision problems				Bedwetting				Animal cruelty		
	Anxiety				Stealing				Unconsciousness		
	Difficulty breathing				Arson / Fires				Frequent vomiting		
	Thyroid Problems				Tremors				Heart palpitations		
	Numbness/tingling				Memory Problems				Stomachaches		
	Running away				Diabetes				Hyperactivity		
	Hearing problems				Poor concentration				Temper tantrums		
	Angry/Resentful				Head injuries				Fighting w/ others		
	Truancy				Fatigue				Bowel problems		
	Seizures				Chronic pain				Dizziness		
	Muscular weakness				Shortness of Breath				Ulcers		
	Hives/rashes				Sleepwalking				Anemia		

Is there any family history of psychiatric (depression, anxiety, substance abuse, legal, or learning problems) or medical problems with any extended family members? If yes, please explain who it is and what kind of problem they have: _____

Were there any problems during the pregnancy with your child, when the child was born, or shortly after birth? Please

explain: _____

Were there any drugs, alcohol, or medications used during the time of conception or by the mother during the pregnancy? If yes, please list.: _____

Were the developmental milestones on time, late, or early? Walking: _____ Talking: _____ Toilet training: _____

Were there any problems with feeding or sleeping when your child was an infant or toddler? _____

Did your child ever have any problems separating from you? _____

Were there any moves, losses, or changes in family structure during your child's life? If so, what were they and when did they occur? _____

Please rate your opinion of your child's development compared to others his/her age in the following areas:

	Below Average	Average	Above Average
Social	_____	_____	_____
Physical	_____	_____	_____
Language	_____	_____	_____
Intellectual	_____	_____	_____
Emotional	_____	_____	_____

Has your child/adolescent ever had any legal problems (tickets, truancy, or theft)? If yes, what? _____

Has your child or adolescent ever had any problems with anger, aggression, or violence? If yes, please explain: _____

Does your child or adolescent have any problems at school? If yes, what? _____

Has your child or adolescent ever have to repeat a grade? If yes, what grade? _____

Briefly describe your child's peer relationships? _____
