Peoples Counseling
& Consulting

"Improved relationships with oneself & others"

4509 South 6th Street, Suite 307
Klamath Falls, Oregon 97603

T 541.274.9551 **F** 541.205.3871
E jaypeoples @ counselingpeople.com
W counselingpeople.com

Jay Peoples MS, MSW, LCSW

History/ Child

Client Name **Date**

Date of Birth **Age**

Gender

Grade in School

Form completed by (if not client)

Address

City **State**

Zip code

Cell Phone

Home Phone

Work Phone

E-mail

Primary Reason for seeking services

(please fill out on back of paper if more room is needed)

❑ Anger Management	❑ Coping
❑ Eating Disorder	❑ Mental Confusion
❑ Sleeping Problems	❑ Alcohol/ drugs
❑ Anxiety	❑ Depression
❑ Fear/ Phobias	❑ Sexual concerns
❑ Addictive behaviors	❑ Hyperactivity

❑ Other mental health concerns (specify):

FAMILY HISTORY

Parents

With whom does the child live at this time?

Are the parents divorced or separated? ❑ Yes ❑ No If yes, who has legal custody?

Were the child's parents ever married? ❑ Yes ❑ No

Is there any information about the parents relationship or treatment toward the child, which might be beneficial in counseling?

❑ Yes ❑ No If yes, describe:

FAMILY HISTORY - CONTINUED

Clients Mother

Name	Age	Occupation	❑ Full-time ❑ Part-time
Current Employment		Work Phone	
Mothers Education			
Is the child currently living with the mother?		❑ Yes ❑ No	
		❑ Natural parent ❑ Step parent ❑ Adoptive parent	
		❑ Foster Home ❑ Other (please specify)	

Is there anything notable, unusual, or stressful about he child's relationship with the mother? ❑ Yes ❑ No (If Yes explain):

How is the child disciplined by the mother?

For what reasons is the child disciplined by the mother?

Clients Father

Name	Age	Occupation	❑ Full-time ❑ Part-time
Current Employment		Work Phone	
Mothers Education			
Is the child currently living with the father?		❑ Yes ❑ No	
		❑ Natural parent ❑ Step parent ❑ Adoptive parent	
		❑ Foster Home ❑ Other (please specify)	

Is there anything notable, unusual, or stressful about he child's relationship with the father? ❑ Yes ❑ No (If Yes explain):

How is the child disciplined by the father?

For what reasons is the child disciplined by the father?

Clients Siblings & Others Who Live in the Household

Name of Siblings	Gender	Lives	Relationship Quality
	❑ M ❑ F	❑ Home ❑ Away	❑ Poor ❑ Average ❑ Good
	❑ M ❑ F	❑ Home ❑ Away	❑ Poor ❑ Average ❑ Good
	❑ M ❑ F	❑ Home ❑ Away	❑ Poor ❑ Average ❑ Good
	❑ M ❑ F	❑ Home ❑ Away	❑ Poor ❑ Average ❑ Good
	❑ M ❑ F	❑ Home ❑ Away	❑ Poor ❑ Average ❑ Good
Others Living in the Household	**Gender**	**Relationship: cousin, foster child, etc...**	**Relationship Quality**
	❑ M ❑ F		❑ Poor ❑ Average ❑ Good
	❑ M ❑ F		❑ Poor ❑ Average ❑ Good
	❑ M ❑ F		❑ Poor ❑ Average ❑ Good
	❑ M ❑ F		❑ Poor ❑ Average ❑ Good
	❑ M ❑ F		❑ Poor ❑ Average ❑ Good

FAMILY HEALTH HISTORY

Have any of the following diseases occurred among the child's blood relatives?
(parents, siblings, aunts, uncles, or grandparents) Please check those which apply:

❑ Allergies	❑ Cancer	❑ Diabetes	❑ Mental illness	❑ Perceptual motor disorder
❑ Anemia	❑ Cerebral Palsy	❑ Glandular problems	❑ Migraines	❑ Mental Retardation
❑ Asthma	❑ Cleft lips	❑ Heart diseases	❑ Multiple sclerosis	❑ Seizures
❑ Bleeding tendency	❑ Cleft palate	❑ High blood pressure	❑ Muscular Dystrophy	❑ Self-harm
❑ Blindness	❑ Deafness	❑ Kidney disease	❑ Nervousness	❑ Spinal Bifida
				❑ Suicide

❑ Other (please specify):

Comments regarding Family Health:

CHILDHOOD ADOLESCENT HISTORY

Pregnancy/ Birth

Has the child's mother had any occurrences of miscarriages or stillborns? ❑ Yes ❑ No

If yes, please describe:

Was the pregnancy with child planned? ❑ Yes ❑ No Length of pregnancy:

Mothers age at child's birth: Father's age at child's birth: Child number: of total children:

How many pounds did the mother gain during pregnancy?

During the pregnancy, did the mother smoke? ❑ Yes ❑ No If yes, what amount:

During the pregnancy, did the mother use alcohol or drugs? ❑ Yes ❑ No If yes, what amount:

While pregnant, did the mother have medical or emotional difficulties? (surgery, hypertension, medications, etc.) ❑ Yes ❑ No

If yes, please describe:

Length of labor: Induced ❑ Yes ❑ No Caesarean ❑ Yes ❑ No

Baby's birth weight: Baby's birth length:

Describe any physical or emotional complications with the delivery:

Describe any complications for the mother or the baby after the birth:

Length of hospitalization: Mother: Baby:

Infancy/ Toddlerhood

Check all that apply:

❑ Breast fed	❑ Resisted soldi food	❑ Cried often	❑ Colic	❑ Diarrhea
❑ Bottle fed	❑ Milk Allergies	❑ Trouble sleeping	❑ Rarely cried	❑ Constipation
❑ Not cuddly	❑ Rashes	❑ Vomiting	❑ Irritable when awakened	❑ Overactive
				❑ Lethargic

CHILDHOOD ADOLESCENT HISTORY - CONTINUED

Developmental History

Please note the age at which the following behaviors took place:

Sat alone:	**Dressed self:**	**Took 1st steps:**	**Tied shoelaces:**	**Spoke words:**
Rode two-wheeled bike:	**Spoke sentences:**	**Toilet trained:**	**Weaned:**	**Dry during day:**
Fed self:	**Dry during night:**			

Compared with others in the family, child's development was: ❑ slow ❑ average ❑ fast

Age for following developments (fill in where applicable)

Began puberty:	**Menstruation:**	**Voice change:**	**Convulsions:**	**Breast development:**

Injuries or hospitalization:

Issues that affected child's development (e.g., physical/ sexual abuse, inadequate nutrition, neglect, etc.):

EDUCATION

Current school:			**School phone number:**	
Type of school:	❑ Public	❑ Private	❑ Home schooled	❑ Other (specify):
Grade:	**Teacher:**	**School Counselor:**		
In special education?	❑ Yes ❑ No	**If Yes, describe:**		
In gifted program?	❑ Yes ❑ No	**If Yes, describe:**		
Has child been held back?	❑ Yes ❑ No	**If Yes, describe:**		

Which subjects does the child enjoy in school?

Which subjects does the child dislike in school?

What grades does the child usually receive in school?

Have there been any recent changes in the child's grades? ❑ Yes ❑ No

If Yes, describe:

Has the child been tested psychologically?	❑ Yes ❑ No	**If Yes, describe:**

Check the descriptions, which specifically relate to your child:

Feelings about School Work

❑ Anxious	❑ Passive	❑ Enthusiastic	❑ Fearful	❑ Eager
❑ No expression	❑ Bored	❑ Rebellious	❑ Other (describe):	

Approach to School Work

❑ Organized	❑ Industrious	❑ Responsible	❑ Interested	❑ Self-directed
❑ No initiative	❑ Refuses	❑ Does only what is expected		❑ Sloppy
❑ Disorganized	❑ Cooperative	❑ Doesn't complete assignments		❑ Other (describe):

Performance in School (Parent's Opinion)

❑ Satisfactory	❑ Underachiever	❑ Overachiever	❑ Other (describe):

Child's Peer Relationships

❑ Spontaneous	❑ Follower	❑ Leader	❑ Long-time friends	❑ Makes friends easily
❑ Shares easily	❑ Difficulty making friends		❑ Other (describe):	

EDUCATION-CONTINUED

Who handles responsibility for your child in the following areas?

School:	❑ Mother	❑ Father	❑ Shared	❑ Other:
Health:	❑ Mother	❑ Father	❑ Shared	❑ Other:
Problem behavior:	❑ Mother	❑ Father	❑ Shared	❑ Other:

If the child is involved in a vocational program or works a job, please fill in the following:

What is the child's attitude toward work?	❑ Poor	❑ Average	❑ Good	❑ Excellent
Current employer:	**Position:**		**Hours per week:**	
How have the child's grades in school been affected since working?		❑ Lower	❑ Same	❑ Higher
How many previous jobs or placements has the child had?				
Usual length of employment:	**Usual reason for leaving:**			

LEISURE/ RECREATIONAL

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/ health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?
1)		
2)		
3)		
4)		

MEDICAL/ PHYSICAL HEALTH

(Check all that apply)

❑ Abortion	❑ Diabetes	❑ Hay fever	❑ Miscarriage	❑ Pneumonia	❑ STD's
❑ Asthma	❑ Diphtheria	❑ Heart Trouble	❑ Multiple Sclerosis	❑ Polio	❑ Thyroid Disorders
❑ Blackouts	❑ Dizziness	❑ Hepatitis	❑ Mumps	❑ Pregnancy	❑ Vision Problems
❑ Bronchitis	❑ Ear Aches	❑ Hives	❑ Muscular Dystrophy	❑ Rheumatic Fever	❑ Glasses
❑ Cerebral Palsy	❑ Ear Infections	❑ Influenza	❑ Nose Bleeds	❑ Scarlet Fever	❑ Whooping Cough
❑ Chicken Pox	❑ Eczema	❑ Lead Poisening	❑ Other Skin Rashes	❑ Seizures	
❑ Congenital Problems	❑ Encephalitis	❑ Measles	❑ Paralysis	❑ Severe Colds	
❑ Croup	❑ Fevers	❑ Meningitis	❑ Pleurisy	❑ Severe Head Injury	

List any current health concerns:

List any recent health or physical changes:

Most Recent Examinations

Type of examination	Date of most recent visit	Results
Physical exam		
Dental exam		
Vision exam		
Hearing exam		

Current prescribed medications	Dose	Dates	Purpose	Side effects

MEDICAL/ PHYSICAL HEALTH - CONTINUED

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Immunization record (check immunizations the child/ adolescent has received):

	DPT	Polio		
2 months	❑	❑	15 months	❑ MMR (Measles, Mumps, Rubella)
4 months	❑	❑	24 months	❑ HBPV (Hib)
6 months	❑	❑	Prior to school	❑ HepB
18 months	❑	❑		
4–5 years	❑	❑		

Nutrition

Meal	How often	Typical foods eaten	Typical amount eaten
Breakfast	( ) times Week		❑ No ❑ Low ❑ Medium ❑ High
Lunch	( ) times Week		❑ No ❑ Low ❑ Medium ❑ High
Dinner	( ) times Week		❑ No ❑ Low ❑ Medium ❑ High
Snack	( ) times Week		❑ No ❑ Low ❑ Medium ❑ High

Comments:

Chemical Use History

Does the child/ adolescent use or have a problem with alcohol or drugs? ❑ Yes ❑ No

If Yes, describe:

COUNSELING/ PRIOR TREATMENT HISTORY

Information about child/ adolescent (past and present)

Treatment	(Please check one)	When	Where	Reaction or overall experience
Suicidal thoughts/ attempts	❑ Yes ❑ No			
Drug/ alcohol treatment	❑ Yes ❑ No			
Hospitalizations	❑ Yes ❑ No			

Other:

BEHAVIORAL/ EMOTIONAL

Please check any of the following that are typical for your child:

❑ Affectionate	❑ Cyber addiction	❑ Frustrated easily	❑ Loner	❑ Sad	❑ Stomach aches
❑ Aggressive	❑ Defiant	❑ Gambling	❑ Low self-esteem	❑ Selfish	❑ Suicidal threats
❑ Alcohol problems	❑ Depression	❑ Generous	❑ Messy	❑ Separation anxiety	❑ Suicidal attempts
❑ Angry	❑ Destructive	❑ Hallucinations	❑ Moody	❑ Sets fires	❑ Talks back
❑ Anxiety	❑ Difficulty speaking	❑ Head banging	❑ Nightmares	❑ Sexual addiction	❑ Teeth grinding
❑ Attachment to dolls	❑ Dizziness	❑ Heart problems	❑ Obedient	❑ Sexual acting out	❑ Thumb sucking
❑ Avoids adults	❑ Drugs dependence	❑ Hopelessness	❑ Often sick	❑ Shares	❑ Tics or twitching
❑ Bed-wetting	❑ Eating disorder	❑ Hurts animals	❑ Oppositional	❑ Short attention	❑ Unsafe behaviors
❑ Blinking, jerking	❑ Enthusiastic	❑ Imaginary friends	❑ Over active	❑ Shy, timid	❑ Unusual thinking
❑ Bizarre behavior	❑ Excessive masturbation	❑ Impulsive	❑ Overweight	❑ Sleeping problems	❑ Weight loss
❑ Bullies, threatens	❑ Panic attacks	❑ Irritable	❑ Weight gain	❑ Self-harm	❑ Withdrawn
❑ Careless, reckless	❑ Expects failure	❑ Lazy	❑ Phobias	❑ Slow moving	❑ Excessive Worry
❑ Clumsy	❑ Fatigue	❑ Learning problems	❑ Poor appetite	❑ Soiling	
❑ Confident	❑ Fearful	❑ Lies frequently	❑ Psychiatric problems	❑ Speech problems	
❑ Cooperative	❑ Frequent injuries	❑ Listens to reason	❑ Quarrels	❑ Steals	

❑ Other: _____

Please describe any of the above (or other) concerns: _____

How are problem behaviors generally handled? _____

What are the family's favorite activities? _____

What does the child/ adolescent do with unstructured time? _____

Has the child/ adolescent experienced death? (friends, family pets, other) ❑ Yes ❑ No **At what age(s)?** _____

If yes, describe the childs/ adolescent's reaction: _____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.) ❑ Yes ❑ No

If Yes, describe: _____

Any additional information that you believe would assist us in understanding your child/ adolescent? _____

Any additional information that would assist us in understanding current concerns or problems? _____

What are your goals for the child's therapy? _____

What family involvement would you like to see in the therapy? _____

Do you believe the child is suicidal at this time? ❑ Yes ❑ No

If Yes, explain: _____

Jay Peoples, M.S., M.S.W., L.C.S.W. **Date**