Dr. Linda Lee
Creative Holistic Counseling

Confidential Psychosocial History - Child

Date: _____ How did you hear about my practice: _____

Child's Full Name: _____

Date of Birth: _____ Age: _____ Grade: _____ School: _____

Birth Location: _____ Religion: _____

Race: ☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Other: _____

Mother's Name: _____

Address: _____
Number and Street City State Zip

Phone: Cell: _____ Can a message be left: ☐ Yes ☐ No
Home: _____ Can a message be left: ☐ Yes ☐ No
Work: _____ Can a message be left: ☐ Yes ☐ No

May I use text messages or email for appointment reminders? Text: ☐ Yes ☐ No Email: ☐ Yes ☐ No

Father's Name: _____

Address: _____
Number and Street City State Zip

Phone: Cell: _____ Can a message be left: ☐ Yes ☐ No
Home: _____ Can a message be left: ☐ Yes ☐ No
Work: _____ Can a message be left: ☐ Yes ☐ No

May I use text messages or email for appointment reminders? Text: ☐ Yes ☐ No Email: ☐ Yes ☐ No

Do you share custody/guardianship with another adult not listed above? __ Yes __ No

Name: _____ Relationship to Child_____

Address: _____
Number and Street City State Zip

Phone: Cell: _____ Can a message be left: ☐ Yes ☐ No
Home: _____ Can a message be left: ☐ Yes ☐ No
Work: _____ Can a message be left: ☐ Yes ☐ No

Is this person aware that you have brought your child in for counseling services? ☐ Yes ☐ No ☐ N/A

Emergency Contact: _____
Name Telephone Relationship to Child

Parent Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Live w/Partner ☐ Widow

Name of Spouse/Significant Other: _____ Length of Relationship: _____

How would you describe the relationship between child and this person? _____

Names and Ages of Siblings: How would you rate the relationship (Excellent/Good/Fair/Poor/No Contact)

1) _____

2) _____

3) _____

4) _____

Any Additional Family Information: _____

_____

_____

_____

Developmental and Educational History:

Were there any pregnancy or birth complications? ☐ Yes ☐ No Please explain: _____

_____

_____

Did your child walk, talk, and read on time? ☐ Yes ☐ No Developmental delays noted? ☐ Yes ☐ No

Please explain: _____

_____

_____

Any repeated grades? ☐ Yes ☐ No: Which grades: _____

Any Special Education classes? ☐ Yes ☐ No: Which classes: _____

_____

Medical History:

Your Assessment of Child's Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of Physician: _____ Practice Location: _____

May I contact your child's physician as part of his/her treatment planning and coordination? ☐ Yes ☐ No

Any serious injuries or hospitalizations: ☐ Yes ☐ No If Yes, please explain: _____

_____

Any head injuries? ☐ Yes ☐ No If Yes, please explain: _____

_____

Allergies: ☐ Yes ☐ No Please list: _____

Medications: _____

_____

Mental Health History:

Has your child received mental health services before: ☐ Yes ☐ No With whom, when, and for how long?

_____

_____

Diagnosis? _____

Psychiatric Hospitalizations? ☐ Yes ☐ No How many? ____ Dates: _____

Past Suicidal Ideation? ☐ Yes ☐ No Current Suicidal Ideation? ☐ Yes ☐ No

Past Homicidal Ideation? ☐ Yes ☐ No Current Homicidal Ideation? ☐ Yes ☐ No

Please briefly describe any history of neglect and/or physical, verbal, emotional, spiritual, sexual or other abuse:

_____

_____

Please briefly describe any history (you or your child) of traumatic experiences? (war, accident, health condition, fire, disaster, etc.)

_____

_____

Any Additional Mental Health Information (include medication): _____

_____

_____

Substance Use History:

Check all that apply: ☐ Alcohol ☐ Caffeine ☐ Tobacco ☐ Marijuana ☐ Other: _____

Substance abuse treatment? ☐ Yes ☐ No Please provide dates, program name, and length of programs:

_____

_____

Any other substance use/abuse history, including family history: _____

_____

Legal History:

Any arrests or incarcerations? ☐ Yes ☐ No Any pending legal issues? ☐ Yes ☐ No
Any military history? ☐ Yes ☐ No If Yes, please describe: _____

_____

Lifestyle:

Describe your child's exercise program: _____

_____

Describe your child's eating habits, food preferences and allergies: _____

_____

Describe your child's typical school day: _____

_____

Describe your child's typical non-school day: _____

_____

Describe your child's sleep habits and pattern: _____

_____

Does you child have regular bowel movements, once or more every day? ☐ Yes ☐ No

Does your child have enough energy to do the things he or she enjoys? ☐ Yes ☐ No

What time of day is best for your child? _____ Worst? _____

How often does your child get out in nature? _____

How much screen time does your child get each day? _____

What type of activities (games, cartoons, etc.)? _____

Your child's strengths: _____

Your child's interests: _____

Your child's areas of challenge: _____

Describe your child's social activities/hobbies/friendships: _____

_____

Describe your home and neighborhood environment: _____

_____

Tell me anything else that is important for me to know about your child and family: _____

_____

_____

Please attach a recent photo here: Alternatively, please check whether you would permit me to take a digital photo to be attached to this child's file for reference: ☐ Yes ☐ No Signature: _____