Oasis Counseling International —333 W. Norfolk Ave., # 201 — Norfolk, NE 68701

CHILD PERSONAL HISTORY FORM (to be completed by parent)

(Rev. 6/16/14)

The purpose of this questionnaire is to obtain a comprehensive view of your child's background to save you and your counselor time. Please be complete and accurate. The information you provide is personal and will be kept confidential to the extent allowed by law. If you desire to not answer a question, simply write: "prefer not to answer." *Please print or write clearly.*

Your name & relationship to child: _____

Child's name: _____ Date of birth: _____/_____/_____

Gender: _____ Race: _____ Living situation (town/farm, house/apartment, etc.): _____

How did you choose Oasis Counseling? _____

Employer/school of parent(s): _____

Please list who lives in the child's home:

Person & relationship	Age	Person & relationship	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRESENTING PROBLEMS

What concerns you most about this child currently? _____

_____

How have these issues affected this child's ability to function (at home, at school, with friends): _____

_____

What goals do you want this counseling to achieve? _____

_____

What specific changes in behavior will indicate to you these goals have been achieved? _____

_____

In addition to counseling for this child, do you also want help for yourself or your marriage? YES NO

If yes, please explain briefly: _____

Does this child have any fears? YES NO If yes, what? _____

How do you handle them? _____

Does this child have any angry outbursts or meltdowns? YES NO If yes, how often? _____

Are there any common causes? _____

What does he/she do? _____

How do you handle them? _____

Does this child have crying spells? YES NO If yes, describe: _____

Does this child have any problems with sleeping? YES NO If yes, describe: _____

Does this child have any problems with focusing or being impulsive? YES NO If yes, describe: _____

To your knowledge, has this child ever thought about or attempted suicide, cutting, running away, or other high risk behaviors?

YES NO If yes, please explain: _____

Other symptoms or stressors (example: physical/medical, social, family, financial): _____

_____

SOCIAL

Does this child belong to any social or athletic groups? YES NO If yes, please specify: _____

What present hobbies, interests, or uses of free time does this child have? _____

_____

Do you believe this child's social behavior is appropriate for his/her age? YES NO

Does this child seek out others of the same age with whom to associate? YES NO

Is this child able to appropriately "hold his/her own" in group situations? YES NO

Does this child have a close friend? YES NO

Does this child relate comfortably with members of his/her own gender? YES NO

Do you have a religious preference? YES NO If yes, what? _____

Does this family participate in a church, synagogue, mosque, or other religious group? YES NO

If yes, please specify: _____

How regular is this family's participation? _____

Does this child also participate regularly? YES NO If yes, in what ways? _____

How open are you to the counselor addressing spiritual issues with this child, if relevant? _____

FAMILY

Marital status of parents (circle one): Married Single Divorced Separated Widowed Live-in relationship

Has anyone other than parents and children lived in this home for an extended period of time? YES NO If yes, please describe who

and when: _____

Which best characterizes this child's overall current home environment?

_____ Unconditional love and acceptance, close relationships
_____ Quiet and peaceful, but relationships are distant
_____ Instability, periods of peace mixed with periods of fighting
_____ Family fighting is the norm
_____ Other: _____

How would you describe the happiness of this child's parents' marriage?

_____ Very much in love, best of friends, happy
_____ Committed to one another, but not particularly close
_____ Unhappy, but trying to make the best of it
_____ Unhappy, avoid one another as much as possible, fights kept secret from children most of the time
_____ Unhappy, much fighting together, often in front of the children
_____ Separated or divorced, but get along with each other
_____ Separated or divorced, and openly antagonistic, ongoing conflicts

Circle what best describes your style of discipline.

Mother:	Strict with little compromise	Firm, but seek to give the child a voice	Lenient	Few Limits

Explain: _____

Father:	Strict with little compromise	Firm, but seek to give the child a voice	Lenient	Few Limits

Explain: _____

If the child was/is not being brought up by her/his parents, who did/is doing the parenting? _____

How old was the child when she/he was removed from the biological parent? _____

Please briefly describe the circumstances. _____

How many times has the family moved since this child was born? _____

What, if any, deaths have occurred among people the child knows? _____(or, *N/A*)

How has the family been impacted by the death(s)? _____

MENTAL HEALTH HISTORY

Has the child had previous counseling? YES NO If yes, with whom? _____

For how long? _____ Approximately when? _____ How was the experience? _____

Has the child ever been hospitalized for psychiatric reasons? YES NO If yes, where, when, why, and for how long? _____

_____

To your knowledge, has the child ever been suicidal? Please explain. _____

SCHOOL

What school does this child attend? _____ Grade: _____

Does this child enjoy school? YES NO

Does this child generally complete his/her homework assignments on time? YES NO

Is working on homework or school projects a problem for this child? YES NO If yes, why? _____

Is this child in a special class? YES NO If yes, what class: _____

Is this child having behavioral problems at school? YES NO If yes, describe: _____

Please circle the word that best describes this child's grades:

Superior Above Average Average Below Average Failing

Has this child missed much school? YES NO If yes, why? _____

Has this child had a recent major change in academic performance? YES NO

Has this child been diagnosed with a learning disability? YES NO If yes, describe: _____

MEDICAL HISTORY

Approximate date of this child's last physical exam: _____/_____/_____

Name and address of her/his doctor: _____

Was this child's development typical? YES NO If not, please explain: _____

Has this child ever been hospitalized? YES NO If yes, for what? _____

Has this child ever had an operation? YES NO If yes, for what? _____

Does this child have any neurological or physical handicaps? YES NO If yes, what? _____

Was there anything remarkable about pregnancy, labor, or delivery with this child? If yes, please explain. _____

_____

Were there any unusual illnesses as an infant? YES NO If yes, what? _____

Has he/she had any motor coordination, visual, speech, learning, or language problems? YES NO If yes, what? _____

_____

MEDICATIONS

Is this child taking medication <u>now</u> (including over-the-counter)? YES NO If yes, please list medicine(s), dosage, and dates taken: _____

_____

Has this child been on any other medication within the <u>last 6 months</u>? YES NO If yes, please list medicine(s), dosage, and dates taken: _____

_____

Does this child have any known medical allergies or reactions? YES NO If yes, what? _____

VICTIM ISSUES

Have you had any indications that this child may have been sexually molested? YES NO If yes, please explain: _____

_____

Have you had any indications that this child may have been physically abused? YES NO If yes, please explain: _____

_____

SUBSTANCES – Does your child intake caffeine through pop or coffee? If so, how much and how often? _____

PERSONAL STRENGTHS AND WEAKNESSES

Please describe any personal strengths, talents, skills, abilities, or accomplishments of this child: _____

_____

Please describe any personal weaknesses and needs of this child: _____

_____

Describe any preferences for therapy (language, learning style, approach): _____

COMMUNITY ACCESS / SOCIAL SUPPORTS

Please list any family members, friends, or others whom you or this child can ask for help or talk to when support is needed: _____

_____

COMMUNITY ACCESS / SOCIAL SUPPORTS

--Please put an "**X**" next to any of the following community supports with which you are **currently** involved.
--On the space provided, please indicate the **name** of the individual with whom you are working, if applicable.
--If you **would like to** be involved with a particular service/support that is listed here, please indicate that on the line provided. (This helps with transition planning and helps your therapist coordinate treatment with other professionals to provide consistent care. Your therapist will **not** contact any of these individuals without your written permission.)

- ☐ Legal services (attorney) _____
- ☐ Norfolk Rescue Mission (crisis housing) _____
- ☐ Correction services (probation or parole officer) _____
- ☐ Local church (pastor/priest) _____
- ☐ HHS case manager _____
- ☐ Liberty Centre (living &/or day services for adult mental health problems) _____
- ☐ Vocational Rehabilitation (employment assistance) _____
- ☐ Employment Works (job skill shadowing and support) _____
- ☐ Financial services (budget and debt counseling) _____
- ☐ Bright Horizons (domestic violence shelter and support) _____
- ☐ Alcoholics Anonymous or Narcotics Anonymous _____
- ☐ Al-Anon (support for family/friends of alcoholics) _____
- ☐ Community support (support/transport for mental health or substance abuse treatment) _____
- ☐ Family support (supervised visitation and education) _____
- ☐ Professional Partners (in-home planning for child/adolescent behavior problems) _____
- ☐ Parent-to-Parent Network (mentoring and peer support for parents) _____
- ☐ HUD or other housing assistance _____
- ☐ Developmental disability services (Envisions, etc.) _____
- ☐ Crisis hotline _____
- ☐ Medication management (psychiatrist or APRN) _____
- ☐ Psychological testing _____
- ☐ I.O.P. program (adolescent or adult intensive therapy for substance abuse) _____
- ☐ Community Health Care Clinic (low-income medical care) _____
- ☐ Recreation services (The Y, or other fitness facilities) _____
- ☐ Support group _____
- ☐ Physical/occupational/speech therapy _____
- ☐ Residential treatment (group home, halfway house) _____
- ☐ Rehabilitation treatment center _____
- ☐ Dietary services (nutritionist) _____
- ☐ Educational services (tutoring, after-school program) _____
- ☐ Mentoring program (Befriend, Teammates, Big Brother Big Sister) _____
- ☐ Any other services _____

*****

*With my **signature** and **date**, I agree that the information in this history form is true to the best of my knowledge:* _____ Thanks for your time and effort!