Relationship Institute

Date of intake:_____

Child/Teen History Form

Parent/Guardian to complete for young children.

Child's Name:_____ Birthdate:_____

Name of adult completing form:_____Relationship_____

Address:_____ Phone_____
City:_____ State:_____ Zip:_____

A. FAMILY AND DEVELOPMENTAL HISTORY

Current Household:	**Mother**	**Father**	**Step-Parent**	**Other Adults**
Name:	_____	_____	_____	_____
Date of Birth:	_____	_____	_____	_____
Current Employer:	_____	_____	_____	_____
How Long Employed:	_____	_____	_____	_____
Occupation:	_____	_____	_____	_____

Who has guardianship/custody of the child?_____
Relationship to the child_____

Names and ages of brothers and sisters living at home:_____

_____

Names and ages of brothers and sisters living elsewhere:_____

_____

With whom are they living:_____

Who supports this child?:_____

B. LIVING ARRANGEMENT

How many residences has child lived in since birth? _____

Cities these residences have been located in?_____

P.2, Intake form continued

Does child share a room with anyone else? No____ Yes____ If no, how long has child had own room?_____ If yes, shares room with whom?_____

Was child adopted? No_____ Yes_____ If adopted, at what age?_____

If yes, is child aware they are adopted? No_____ Yes_____

Length of pregnancy:_____(months) Was pregnancy easy?_____ Difficult?_____

Was infant premature? No_____ Yes _____ If yes, how many months?_____

Did mother receive any medication during delivery?_____

Did infant receive any medication? No_____ Yes_____ If yes, what kind?_____

Has child had any problems with vomiting, diarrhea, constipation or colic? No ____ Yes_____

Please specify type, how long, and what age:_____
_____

Have there been any sleep problems, head banging, thumb sucking, teeth grinding, temper tantrums? No_____ Yes_____ Specify/Describe:_____

_____

When did your child stand alone?_____ Walk?_____ Use words?_____

Speak in sentences?_____ If there were any problems, please describe:_____

_____

When was your child toilet-trained: Bladder - Day_____ Night_____

Bowel _____

Any problems? No _____ Yes_____ Please describe:_____

_____

_____

P.3, Intake form continued

SCHOOL-AGE:

Did/does your child attend a pre-school/day care program? No_____ Yes_____

If yes, what age? _____ For how long?_____

What is your child's current grade level? K 1 2 3 4 5 6 7 8 9 10 11 12

Recent average grade: A B C D E Has there been a change in grade average in the past six (6) months? No ____ Yes_____ If yes was change up?_____ Down? _____ Has your child ever been in a Special Education program? No_____ Yes_____ If yes, where?_____

When?_____ How long?_____ What grades?_____

Has your child repeated any school grades? No_____ Yes_____ If so, when?_____

Which grade(s)?_____ Has your child ever been tutored or received special help?_____

If yes, when?_____ What subjects?_____

Has your child ever been suspended from school? No ____ Yes____ Expelled? No____ Yes___

If yes, please explain the circumstances:_____

_____

ADOLESCENCE:

If your child is a teenager, what physical changes have you noticed?_____

_____

Have you noticed a change in your child's attitude towards: School _____ Family_____

Friends_____ Recreational Activites_____ Please describe:_____

_____

Does your child have a paying job? No_____ Yes_____ If yes, where?

How many hours worked per week?_____ Has your child ever discussed future plans with you? No____ Yes____ Please describe them:_____

D. DRINKING HISTORY

Age at time of: First drink_____ First intoxication_____ Recognition of problem_____
Drink preference(s):_____
Quantity:_____
Frequency:_____

DRUG HISTORY

List all drugs used: _____ _____ _____ _____

Age at time of first use:_____ _____ _____ _____

First Problem: _____ _____ _____ _____

Quantity: _____ _____ _____ _____

Frequency: _____ _____ _____ _____

Does the child smoke cigarettes? _____ Yes _____ No

Chemical Dependency Treatments - (detox, inpatient, residential)

Diagnosis	Facility	Date
_____	_____	_____
_____	_____	_____

Family use of alcohol, other drugs (include mother, father, siblings)

Relationship	Type	Quantity	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has parental figure ever underdone treatment or received help for an alcohol or drug problem?

If so, who?_____ When?_____

From what source was help sought?_____

E. PREVIOUS PSYCHOLOGICAL OR PSYCHIATRIC TREATMENT

Has the child ever been seen for emotional problems? No____ Yes_____ If yes, by whom and when?_____

Have other family members had emotional problems? No_____ Yes _____ If yes, please describe:_____

Has this child ever lived away from home because of emotional problems or family problems? No_____ Yes_____ If yes, please describe:_____

_____

Has this child ever been in trouble with the court(s) and/or police? No____ Yes____ If yes, please describe:_____

F. SOCIAL

How would you describe your child's social network of friends?_____

_____

Is there any spiritual/religious/philosophical tradition(s) or teachings which have had a significant effect on the family?_____

_____

What are your child's strengths and talents?_____

_____

What are your child's favorite leisure activities?_____

What brings you to therapy at this time?_____

_____

What do you hope to get out of therapy at this time?_____

_____

Anything else you would like to add?_____

_____

_____

Thank you!