

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
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Name:	_____	_____	_____	_____
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Date of Birth:	_____	_____	_____	_____
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Current Employer:	_____	_____	_____	_____
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How Long Employed:	_____	_____	_____	_____
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Occupation:	_____	_____	_____	_____
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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: _____

P.4, Intake form continued

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 undergone treatment or received help for an alcohol or drug problem?

If so, who? _____ When? _____

From what source was help sought? _____

P.5 Intake form continued

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!