CONFIDENTIAL
Child / Adolescent Health History

Please write or print clearly. All of your information will remain confidential between you and the Health Coach.

PERSONAL INFORMATION

First Name: _____

Last Name: _____

Email: _____ How often do you check email? _____

Phone: _____ May we leave a message here?: Yes ☐ No ☐

Age: _____ Height: _____ Birthdate: _____ Place of Birth: _____

PARENT INFORMATION

Mother's Name: _____ May we contact client's mother?: Yes ☐ No ☐

Preferred Phone Number: _____ Email: _____

Father's Name: _____ May we contact client's father?: Yes ☐ No ☐

Preferred Phone Number: _____ Email: _____

Primary Custodian *(if other than parent):* _____

Relationship to client: _____ May we contact client's father?: Yes ☐ No ☐

Preferred Phone Number: _____ Email: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____

TERMS OF SERVICE

I understand that it is customary to pay for professional services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of cancellation, I will be charged the full fee for professional service.

Signed: _____ Date: _____

All accounts are requested to have a credit card on file to reserve appointments. This information will be kept confidential and will only be used to process payments at your request or to bill for late cancellations and missed appointments.

Credit Card Number: _____ Exp. Date: _____

Billing Zip Code: _____ Card Type: ☐ VISA ☐ MASTERCARD

Four Winds
COUNSELING CENTER

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Child / Adolescent Health History

TO BE COMPLETED BY CHILD / ADOLESCENT CLIENT:

SOCIAL INFORMATION

Do you enjoy school? Please explain: _____

Do you have a large or small group of friends? _____

Who is your best friend? _____

_____

What do you do for fun? _____

_____

What is your favorite sport or activity? _____

_____

What are fun things you do with family? _____

_____

What are your favorite things to do when you are alone? _____

_____

What chores do you do around the house? _____

_____

HEALTH INFORMATION

When is bedtime? _____ When do you wake up? _____

Do you ever wake up at night? _____ Do you ever have nightmares? _____

Do you get bellyaches? _____ Do you get headaches or earaches? _____

What is your ancestry? _____ Do you get itchy? _____

MEDICAL INFORMATION

Do you have allergies or sensitivities? _____

_____

Does anything else hurt? _____

_____

Four Winds COUNSELING CENTER

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Child / Adolescent Health History

FAMILY HISTORY

How would you describe your relationship with your mother? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How would you describe your relationship with your father? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have stepparents? ☐ Yes ☐ No

If yes, how would you describe your relationship with your stepparents? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have siblings? ☐ Yes ☐ No

If yes, how would you describe your relationship with your siblings? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

SUBSTANCE USE

Which of the following have you tried or used?

☐ Wine
☐ Beer
☐ Cocaine
☐ Cigarettes
☐ Speed
☐ Marijuana
☐ Liquor
☐ Downers
☐ Over-the-Counter Medicine
☐ Ecstasy
☐ LSD
☐ Heroin
☐ Tobacco
☐ PCP
☐ Prescription Drugs
☐ Other: _____

At what age did you first use drugs? _____

Have you ever used drugs before or during school? ☐ Yes ☐ No

Have you ever missed school because of substance use? ☐ Yes ☐ No

Do you ever feel pressure to use? ☐ Yes ☐ No

If you use drugs or alcohol, how often do you use them?

☐ Everyday
☐ 2+ times per week
☐ Weekends
☐ 1-2 times per month
☐ Once a year
☐ Holidays
☐ Other: _____

ABUSE / TRAUMA

Have you ever been abused? ☐ Yes ☐ No If yes, please describe: _____

Have you ever been sexually abused? ☐ Yes ☐ No If yes, please describe: _____

Have you been emotionally or mentally abused? ☐ Yes ☐ No

If yes, please describe: _____

Have you ever experienced other severe trauma? ☐ Yes ☐ No

If yes, please describe: _____

MENTAL STATUS

How would you describe yourself?

☐ Happy
☐ Lonely
☐ Sad
☐ Depressed
☐ Hurt
☐ Angry
☐ Other: _____

Do you see or hear things others do not? ☐ Yes ☐ No If yes, please describe: _____

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LEVEL OF DISTRESS

Indicate how distressed you are by placing an "X" on the scale below:

1 2 3 4 5 6 7 8 9 10
Very Little Distress — Extreme Distress

Are you currently experiencing any suicidal thoughts? □ Yes □ No

Have you experienced them in the past? □ Yes □ No

Have you ever attempted suicide? □ Yes □ No

Have any of your friends or family ever committed or attempted suicide? □ Yes □ No

TO BE COMPLETED BY PARENT / GUARDIAN:

MEDICAL INFORMATION (Continued)

Primary Physician: _____ City: _____ Zip: _____

Specialty (eg. Family Practice, OB/GYN, Internal Medicine): _____

List significant conditions, illnesses, surgeries, hospitalizations, traumas, or treatments you've had (use back if necessary): _____

_____

_____

List all current medications you are taking, including those you seldom use or take only as needed (use back if necessary).

Medication	Dosage	Purpose for Medication

Are you taking these medication(s) according to your doctor's recommendations? □ Yes □ No

If no, briefly explain: _____

GENERAL INFORMATION

What has led you to seek counseling / coaching for your child at this time? _____

_____

What specific goals do you hope your child will achieve during this experience? _____

_____

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Child / Adolescent Health History

FAMILY HISTORY

Please check any of the following physiological symptoms that apply to you presently or in the recent past:

Headaches	□ Past	□ Present	Dizziness	□ Past	□ Present	Stomach Trouble	□ Past	□ Present
Visual Trouble	□ Past	□ Present	Sleep Trouble	□ Past	□ Present	Trouble Relaxing	□ Past	□ Present
Weakness	□ Past	□ Present	Tension	□ Past	□ Present	Rapid Heart Rate	□ Past	□ Present
Difficulty Breathing	□ Past	□ Present	Intestinal Trouble	□ Past	□ Present	Hearing Noises	□ Past	□ Present
Change in Appetite	□ Past	□ Present	Tiredness	□ Past	□ Present	Pain	□ Past	□ Present
Hearing Voices	□ Past	□ Present	Seeing Things	□ Past	□ Present	Other:		

Please check any of the following problems that apply to you and/or your family:

Stress	□ You	□ Family	Nervousness	□ You	□ Family	Anxiety	□ You	□ Family
Panic	□ You	□ Family	Unhappiness	□ You	□ Family	Depression	□ You	□ Family
Guilt	□ You	□ Family	Apathy	□ You	□ Family	Terminal Illness	□ You	□ Family
Recent Death	□ You	□ Family	Grief	□ You	□ Family	Hopelessness	□ You	□ Family
Inferiority Feelings	□ You	□ Family	Defective Feelings	□ You	□ Family	Loneliness	□ You	□ Family
Shyness	□ You	□ Family	Fears	□ You	□ Family	Friends	□ You	□ Family
Marriage	□ You	□ Family	Communication	□ You	□ Family	Physical Abuse	□ You	□ Family
Emotional Abuse	□ You	□ Family	Verbal Abuse	□ You	□ Family	Sexual Abuse	□ You	□ Family
Temper	□ You	□ Family	Anger	□ You	□ Family	Aggressiveness	□ You	□ Family
Bad Dreams	□ You	□ Family	Concentration	□ You	□ Family	Racing Thoughts	□ You	□ Family
Unwanted Thoughts.	□ You	□ Family	Memory	□ You	□ Family	Loss of Control	□ You	□ Family
Impulsive Behavior.	□ You	□ Family	Self-Control	□ You	□ Family	Compulsivity	□ You	□ Family
Sexual Problems	□ You	□ Family	Pregnancy	□ You	□ Family	Abortion	□ You	□ Family
Legal Matters	□ You	□ Family	Trauma	□ You	□ Family	Eating Problems	□ You	□ Family
Drug Use	□ You	□ Family	Alcohol Use	□ You	□ Family	Trouble with Job	□ You	□ Family
Career Choices	□ You	□ Family	Ambition	□ You	□ Family	Making Decisions	□ You	□ Family
Children	□ You	□ Family	Being a Parent	□ You	□ Family	Finances	□ You	□ Family
Recent Loss	□ You	□ Family	Disaster	□ You	□ Family	Other	□ You	□ Family

ADDITIONAL COMMENTS

Anything else you would like to share? _____

_____

_____

_____

I verify that the information provided above is accurate to the best of my knowledge.

Signature of Child / Adolescent : _____ Date: _____

Signature of Parent / Guardian: _____ Date: _____