Child/Adolescent Personal History Form

MIGHTY OAK
CHRISTIAN COUNSELING

A. Identification Data

Child/Adolescent's name _____ SSN _____-____-_____
Address _____City/State _____ Zip _____
Gender _____ Birthdate ____/____/____ Age: ____ Phone# _____ ☐Home ☐Cell
Nationality or Ethnic Background _____ Email _____
Parent or Guardian Name(s) and relationship to child/Adolescent _____
_____
Address if different than above _____
City/State _____ Zip _____

B. Education (circle last year completed)

Grade School 1 2 3 4 5 6 7 8 High School 9 10 11 12
School _____
Are any of the concerns brining you to counseling related to academic/social problems at school? ☐Yes ☐No
If so, what are these concerns? _____
_____
_____

Church/Synagogue _____ Pastor/Rabbi_____
Usual Church Attendance ____ times per ☐Week ☐Month ☐ Year ☐Am not attending currently
How important is your faith/spirituality to your family? _____

C. Health History

Rate your physical health (check) ☐Very good ☐Good ☐Average ☐Poor
Your approximate weight (lbs.) _____ recent weight changes Lost ____ Gained ____ Height _____
List all known allergies _____
List all significant present or past illnesses, injuries, hospitalizations, or disabilities _____
_____
_____
Current Primary Care Physician _____ Date of last medical exam _____
Other Physicians treating you presently or in last five years _____
Date of Last visit _____ Recent Medical Reports? _____
What kinds of physical exercise do you get? _____
_____
_____ How often? _____
Do you try to restrict your eating in any way? ☐No ☐Yes. If yes, how and why? _____
_____
Do you have any problems getting enough sleep? ☐No ☐Yes. If yes, what problems? _____
_____

Are you taking any medications prescribed by a physician? ☐No ☐Yes If yes, please list below.

Medication	Date began	Daily Dose	Condition treated	Prescribing physician

"over the counter" medications or herbal supplements _____
_____

D. Treatment History

Have you ever had any psychotherapy before or counseling? ☐No ☐Yes If yes, please give details including name of hospital, length of stay, and reason for stay _____
_____
_____
_____

Have you ever attempted suicide? ☐No ☐Yes If so, when and in what manner?_____

E. Legal History

Have you ever been arrested? ☐No ☐Yes If yes, describe the charges and circumstance _____
_____
_____

Have you ever been physically abusive or been treated in a physically abusive manner in an intimate (marital/dating) relationship? ☐No ☐Yes If yes, please describe _____
_____
_____

Have you ever sought a protection order against anyone or had a protection order taken out against you? ☐No ☐Yes If yes, when/who? _____

Have you ever been afraid that a friend or family member would physically harm you? ☐No ☐Yes

F. Information about Other Family Members in the home.

Name	Age	Grade last completed	Relevant Comments
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____

Other significant Family Members or Non-Family members NOT living in the home

Name	Age	Relationship to client	Relevant comments
_____	_____	_____	_____
_____	_____	_____	_____
Other _____	_____	_____	_____

G. Parental/Family History

If raised by someone other than parents, please explain _____
_____ Are you adopted? ☐No ☐Yes

Occupation of Father? _____ Mother_____

Does either parent/caretaker drink excessively or use drugs? ☐No ☐Yes if yes, explain_____
_____

Has there been any recent deaths or losses? _____
_____
_____

H. Strengths and Supports (may be answered by parent/guardian or minor client)

Who do you consider to be part of your current support system? _____
_____
_____

What do you think your personal strengths/positive qualities are? What are you good at? _____
_____
_____

What concerns would you like addressed in counseling? _____
_____
_____
_____

What have you done about these concerns to this point? _____
_____
_____

Is there anything that recently happened or a behavior that you were especially concerned about that caused you to seek treatment at this time? _____
_____
_____
_____

Signature of person completing form: _____ Date: _____

Relationship to client: _____

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Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" packet. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.) I understand the payment/fee for service policies of Mighty Oak Christian Counseling.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be allowed to reschedule with a $10.00 fee. Repeated no-show and no-call ahead missed appointments will lead to closure of services.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____
Signature of client (or person acting for client) Date

_____ _____
Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and response give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of therapist Date

☐Copy accepted by client ☐Copy declined by client

Client Information

Client Information

Client Name: _____ DOB:_____ Sex:_____
SSN: _____ Phone #: _____☐ home ☐cell ☐work
Address:_____
Email: _____

Contact Information

If our office needs to contact the client what is the best # to call? _____
Is it ok for us to leave a message on voicemail/answering machine? _____
Is it ok to leave a message with someone besides yourself at your number? _____
List the individuals a message may be left with: _____
_____
_____

Payment Options

___ I plan to pay at time of service or through prearranged billing contract.

___ I would like the service submitted to my insurance and understand that I may still be responsible for all or a portion of the fee.

Insurance

Insured Party: _____ Relationship to Client: _____
Address: _____
Insurance Company: _____ Phone #: _____
Policy #: _____ Group #:_____
Insured Party SSN: _____ Insured Party DOB: _____

Secondary Insurance

Dual Coverage? _____ 2nd Insurance Company: _____
Insured Party: _____ Relationship to Client: _____
Phone #: _____ Address: _____
Policy #: _____ Group #: _____
Insured Party SSN: _____ Insured Party DOB: _____

I verify that the above information is factual and true to the best of my knowledge. If noted, I authorize the office to bill/submit services to insurance. I understand that payment, proof of insurance, and/or copay is due at the time of service.

I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

_____ _____

Client Date