FURMAN FAMILY COUNSELING, LLC
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Child and Adolescent History and Assessment

Today's Date: _____

A. Identification

1.Child's Full Name: _____
Gender: _____ Preferred Pronouns: _____
Date of birth: _____ Age: ___
Nickname: _____ Social Security number: xxx-xx-_____
Person completing this form: _____
Home address: _____
City: _____State: _____ Zip code: _____
Home phone: _____ e-mail: _____
Cell: _____
Calls or e-mail will be discreet, but please indicate any restrictions: _____
_____

2. Mother's name: _____ Date of birth: _____ Age: ____
Address: _____
Home phone: _____ OK to leave message: Y____ N____
Cell phone/pager: _____ OK to leave message: Y____ N____
Currently employed: __ Yes __ No
Current employer: _____ Work phone: _____

3. Father's name: _____Date of birth: _____ Age: _____
Address: _____
Home phone: _____ Cell phone/pager: _____
Currently employed: __ Yes __ No
Current employer: _____Work phone: _____

4. Parents are currently: __ Married __Divorced __Remarried __Never married
__Other; Child's custodian/guardian: _____

5. Stepparent's name: _____ Date of birth: _____ Age: ___
Address: _____
Home phone: _____ Cell phone/pager: _____
Currently employed: __ Yes __ No
Current employer: _____ Work phone: _____

6. Stepparent's name: _____ Date of birth: _____ Age: ___
Address: _____
Home phone: _____ Cell phone/pager: _____
Currently employed: __ Yes __ No
Current employer: _____ Work phone: _____

7. Custody Arrangements:
Mother: Sole Physical _____; Sole Legal _____
Joint Physical _____; Joint Legal _____
Father: Sole Physical _____; Sole Legal _____
Joint Physical _____; Joint Legal _____

B. Referral: Who gave you my name (our agency) to call?
Name: _____ Phone: _____
Address: _____
_____
May I thank this person for the referral? __ Yes __ No
How did this person explain how I might be of help to you?_____

C. Emergency Information
Emergency contact person: _____
Relationship: _____ Phone number: _____

D. Chief Concern
Please describe the main difficulty that has brought you to see me: _____
_____
_____

E. Checklist of Concerns
Check all that apply to your child.

__ Abuse (Current emotional, physical, verbal, sexual)
__ Abuse (Past emotional, physical, verbal, sexual)
__ Aggression/violence
__ Alcohol/substance use
__ Alcohol/substance use of loved one
__ Anxiety,nervousness
__ Attention,concentration,distractibility
__ Bullies, intimidates, provokes others
__ Depression, low mood, sadness
__ Divorce, separation, remarriage (parents)
__Eating problems
__Failure in school
__ Fighting, hitting, hostile, destructive
__ Gambling
__Grieving, mourning, losses, deaths
__Health issues, medical concerns
__Interrupts, talks out, yells
__ Impulsiveness, loss of control, outbursts
__ Lack of respect for authority, insults, dares
__ Learning disability, learning issues
__ Low frustration tolerance, irritability
__ Mood swings
__ Nightmares, night terrors
__Oppositional, resists, refuses, doesn't comply
__ Overactive, restless, hyperactive, fidgety
__ Parenting, child management, single parent issues
__ Recent move, new school, loss of friends
__ Relationship problems (friends, relatives, siblings
__ Self-esteem
__ Self-harm/self-injurious behaviors (cutting, head banging, hitting self)
__ Sexual issues (preoccupation, public masturbation, inappropriate sexual behaviors, sexual orientation, gender identity)
__ Sleep problems – too much, too little
__ Suicidal thoughts or attempts
__ Teased, bullied, victimized
__ Temper problems, self-control issues
__ Tics- involuntary rapid movements
__ Trauma survivor or witness
__ Truant, avoids school
__ Weight and diet issues
__ Wetting or soiling issues
__ Withdraws from others, isolates
__ Other (specify): _____

F. Living Environment
List all people living in the home. Indicate which children are from a previous marriage or relationship with the letter P in the last column.

Name	Relationship	Date of birth	P?

Children not living in the home:

Name	Relationship	Date of birth	P?

G. Developmental History

1. Pregnancy and delivery
   Prenatal medical illnesses and health care: _____
   _____
   Was your child premature? _____ Weight and height at birth: _____
   Any birth complications or problems? _____

2. The first few months of life
   Breast fed? ___ If so, for how long? _____

3. Developmental milestones: At what age did this child do each of these? If uncertain, indicate if within normal limits (WNL)
   Sat without support: _____ Crawled: _____ Walked without holding on: _____
   Helped when being dressed: _____ Ate with a fork: _____ Stayed dry all day: _____
   Didn't soil pants: _____ Stayed dry all night: _____ Tied shoelaces: ____
   Buttoned buttons: _____

4. Speech/language development
   Age when child said first word understandable to a stranger: _____
   Age when child said first sentence understandable to stranger: _____
   Any speech, hearing or language difficulties? _____
   _____

5. Allergies: _____

6. Sleep patterns or problems: _____
   _____

7. Personality characteristics:_____
   _____

H. Health (Physical) History

Primary care doctor/clinic's name: _____
Phone: _____
Address: _____
_____

If your child enters treatment with me may I contact your child's doctor so that he or she can be fully informed and we can coordinate treatment? ___ Yes ___No

List all of childhood illnesses, hospitalizations, medications, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures and other medical conditions.

Condition	Age	Treated by whom?	Consequences

I. Mental Health/Counseling History

1. Has your child ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? ___ No ___Yes If yes, please indicate:

Date	Provider	Presenting problem	Results

2. Has your child ever taken medications for psychiatric or emotional problems? __No __ Yes
If yes, please indicate:

Date	Provider	Medications	Presenting problem	Results

J. Residences

1. Homes

Dates					
From	To	Location	With whom	Reason for moving	Any problems?

2. Residential placements, foster care, institutional places

Dates				
From	To	Program name	Reason for placement	Problems?

K. Schools

School (name, district, address, phone)	Grade	Teacher

May I call and discuss your child with the current teacher? ____Yes ____ No

L. Special skills or talents of child

List hobbies, sports; recreational musical, TV and toy preferences: etc.: _____
_____
_____

M. Religious and racial/ethnic identification (optional)

Religious denomination/affiliation: __ Protestant __ Catholic __ Jewish __ Islamic __ Buddhist ___ Hindu __ Other (specify): _____
Involvement: __ None __ Some/irregular __ Active
Ethnicity/national origin: _____ Race: _____

N. Other

Is there anything else I should know that does not appear on this form that may be helpful to the counseling? _____
_____

(7/17)