THE CALLI INSTITUTE
a **balanced approach** to mental health

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Personal History – Child/Adolescent

Today's Date: ____ /____ /____

Name: ______________________________ What does your child like to be called? ____________________

Sex: M F (circle one) Age: ________ Birthdate: ____ /____ /____

Mother's name: ____________________________ Father's name: ____________________________

Step parent(s) / legal guardian: ____

Pediatrician / Clinic: ____

Do you want us to contact this provider regarding your child's care here? ☐ Y ☐ N

What is the primary reason for seeking services? ____

Your Child's Past Medical History: (mark all that your child has or has had)

☐ Allergies
☐ Anemia
☐ Asthma
☐ Arrhythmia / heart murmur
☐ Cancer / tumor
☐ Congenital or acquired heart disorder
☐ Diabetes
☐ Ear infections
☐ Epilepsy/seizures
☐ Hepatitis
☐ High blood pressure
☐ HIV / AIDS
☐ Liver problems
☐ Kidney problems
☐ Migraines
☐ Pneumonia
☐ Speech, hearing or visual impairment
☐ Thyroid disease
☐ Tuberculosis
☐ Ulcers
☐ Other: ____________________

- Were there any problems with pregnancy or childbirth? ☐ Yes ☐ N

  If yes, please describe: ____
- Was your child exposed to prenatal alcohol, drug use, or tobacco? ☐ Yes ☐ N

  If yes, please describe: ____
- Did your child meet all developmental milestones on time? ☐ Yes ☐ N

  If no, please describe: ____
- When was your child's last physical exam? ____________________
- *If female:* Has your daughter started menstruating? ☐ Yes ☐ N

  Do your daughter's mental health symptoms worsen around her period? ☐ Yes ☐ N

Past Surgeries: (type of surgery and approximate year) ☐ None

1. ____
2. ____
3. ____

Past Injuries: (type of injury and approximate date) ☐ None

1. ____
2. ____
3. ____

Current Medications: ***Allergies:*** ______________________________

Medication/Dose	Reason	Medication/Dose	Reason

- Who is prescribing your child's medications? ____

Family Health History: (mark if a blood relative has or had any of the following problems)

- ☐ Alzheimer's
- ☐ Anxiety
- ☐ ADHD
- ☐ Alcoholism
- ☐ Bipolar Disorder
- ☐ Brain tumor
- ☐ Brain aneurysm
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Epilepsy / seizures
- ☐ Migraines
- ☐ Heart disease
- ☐ Huntington's
- ☐ Multiple sclerosis
- ☐ Neuropathy
- ☐ Parkinson's
- ☐ Schizophrenia
- ☐ Stroke
- ☐ Tics / Tourette's
- ☐ Tremor
- ☐ Other: ___________________
- ☐ Completed suicide

Your Child's Past Mental Health History: (mark all that your child has or has had)

- ☐ Anxiety
- ☐ ADHD
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Eating disorder: ______________________
- ☐ Learning disorder: ______________________
- ☐ Obsessive-compulsive disorder
- ☐ Panic attacks
- ☐ Personality disorder
- ☐ Phobia (extreme fear of something)
- ☐ Post Traumatic Stress Disorder
- ☐ Substance abuse: ____________________
- ☐ Social or separation anxiety
- ☐ Tourette's disorder
- ☐ Other: ______________________________

- Has your child done therapy in the past? ☐ Yes ☐ No

  If yes, when and with whom? ____

  Was it helpful? ☐ Yes ☐ No If no, why not? ____

- Has your child ever been tested by a psychologist? ☐ Yes ☐ No

  If yes, can we obtain a copy of the testing? ☐ Yes ☐ No

  If yes, please provide the name of the psychologist, clinic and approximate testing date(s): ____________________

  ____

- Has your child ever taken medications for a mental health disorder? ☐ Yes ☐ No

  If yes, who prescribed them? ____

  Please list what he/she has taken: ____

- Has your child ever been hospitalized for a mental health issue? ☐ Yes ☐ No

  If yes, how many times? ______ When/where was the last hospitalization? ______________________

- Has your child ever attempted to hurt him or herself? ☐ Yes ☐ No

  If yes, how so? ______________________________ When was the last attempt? ______________

- Has your child ever become violent toward others or destroyed property? ☐ Yes ☐ No

  If yes, please describe: ____

- Has your child ever been the victim of emotional, physical or sexual abuse? ☐ Yes ☐ No

  If yes, please describe when and the nature of the abuse: ______________________________

  Was/is Child Protective Services (CPS) involved? ☐ Yes ☐ No

  If yes, who was/is the case manager and through which county? ___________________________

- Are there any other mental health providers involved in your child's care? ☐ Yes, __________________ ☐ No

  If yes, do you want us to contact him/her regarding this assessment? ☐ Yes ☐ No

Social History:

Family:

Parents are: ☐ never married ☐ married ☐ separated ☐ divorced ☐ widowed

Parents remarried? ☐ Yes, ______________________________ ☐ No

Siblings: (please list names & ages) ______________________________

Special circumstances (e.g., foster care, adopted, child being raised by someone other than parents, custody arrangements): ______________________________

____

____

____

People currently living in the home:

Name	*Relationship to the child*	*What concerns, if any, exist regarding this relationship?*

Friends:

Has your child's friend group changed within the last year? ☐ Yes ☐ No

Do you have any concerns regarding your child's friendships? ☐ Yes ☐ No

If yes, please describe: ______________________________

Has your child ever been bullied? ☐ Yes ☐ No

If yes, please describe: ______________________________

Education:

Is your child currently enrolled in school / daycare? ☐ Yes ☐ No

How many schools or daycares has your child attended in the last year? ______________________________

Name of school / daycare: ____________________ Grade: ________ Name of teacher: ____________________

Describe your child's academic performance over the pas school year (circle one): GOOD FAIR POOR

If POOR, please describe: ______________________________

Legal:

Has your child ever been involved with the legal system?

If yes, please describe: ______________________________

Spiritual/Cultural:

Do you have any specific spiritual/religious or cultural beliefs and/or practices? ☐ Yes ☐ No

If yes, please describe: ______________________________

How important is spirituality to you (circle one)? VERY SOMEWHAT NOT AT ALL

Behavioral Information:

- Have there been any significant events in your child's life in the past 12 months? ☐ Yes ☐ No

  If yes, please describe: ____________________
- Have you see a significant change in your child's history within the past 12 months? ☐ Yes ☐ No
- If yes, please describe: ____________________
- Describe your child's fears: ____________________
- How does your child show affection? ____________________
- How does your child show anger? ____________________
- What are some of your child's favorite activities? ____________________
- Does your child have any difficulties in any of the following areas (check all that apply)?

Health
☐ weight loss
☐ weight gain
☐ diet / eating
☐ use of drugs / alcohol
☐ caffeine / nicotine

Emotions
☐ mood swings
☐ frequent crying
☐ depressed mood
☐ socially withdrawn
☐ suicidal thoughts / attempts

Sleep
☐ bed wetting
☐ nightmares
☐ falling asleep
☐ staying asleep
☐ afraid to sleep in own bed

Development
☐ soils pants
☐ sucks thumb / finger
☐ motor skills
☐ language skills

Behaviors
☐ lying / exaggerating
☐ cruelty to animals
☐ fascination with fire / weapons
☐ sexual acting out
☐ nervous habits
☐ truancy

Relationships
☐ getting along with other kids
☐ getting along with other adults
☐ dating

Discipline Techniques:

Mother: ____________________

Father: ____________________

Step Parent(s) / Legal Guardian: ____________________

Additional Information:

- How does your child feel about coming to therapy? ____________________

  ____

  ____
- Is there any other information you think is important for me to know about your child? ____________________

  ____

  ____
- What do you hope your child will gain from therapy? ____________________

  ____

  ____

Parent/Guardian Signature: ____________________ Date: _____ / _____ / ______