Susan LaFreniere & Associates

Susan LaFreniere, LMSW, ACSW, CDP, PC
Clinical Psychotherapist

Jill A. Esterly-Jayne, LMSW
Clinical Psychotherapist

Lisa Kerrigan, RN, CNC
Holistic Health Practitioner

104 E. Washington St. • Marquette, MI 49855 • Ph: 906-228-3092 Fax: 906-273-1434 • susanlafreniere.com

Personal History (Child/Adolescent) for: _____ Date: _____ Case #: _____
(Please Print Child's Name)

Gender: ___ F ___ M Date of birth: _____ Age: _____ Grade in school: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: ____ Zip: _____

Phone (home): _____ (work): _____ Ext: _____

If you need any more space for any of the following questions please use additional sheets.

Primary reason(s) for seeking services:

___ Anger management ___ Anxiety ___ Coping ___ Depression

___ Eating disorder ___ Fear/phobias ___ Mental confusion _____

Sexual concerns

___ Sleeping problems ___ Addictive behaviors _____ Alcohol/drugs ___ Hyperactivity

___ Other mental health concerns (specify): _____

_____

Family History

Parents

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

If Yes, who has legal custody? _____

Were the child's parents ever married? ____ Yes _____ No

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? _____ Yes _____ No

If Yes, describe: _____

Client's Mother

Name: _____ Age: ____ Occupation: _____ _____ FT ___ _____ PT

Where employed: _____ Work phone: ___ _____

Mother's education: _____

Is the child currently living with mother? ___ Yes _____ No

___ Natural parent _____ Step-parent ___Adoptive parent _____ _Foster home ___ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the mother?

___ Yes ___ No If Yes, please explain: _____

_____

How is the child disciplined by the mother? _____

For what reasons is the child disciplined by the mother? _____

Client's Father

Name: _____ Age: ____ Occupation: _____ _____ FT ___ _____ PT

Where employed: _____ Work phone: __ _____

Father's education: _____

Is the child currently living with father? _____ Yes _____ No

___ Natural parent _____ Step-parent ___Adoptive parent _____ __Foster home ___ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the father?

___ Yes ___ No If Yes, please explain: _____ _____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
_____	___	___ F ___ M	___ home _____ away	___ poor __ average _____ good
_____	___	___ F ___ M	___ home _____ away	___ poor __ average _____ good
_____	___	___ F ___ M	___ home _____ away	___ poor __ average _____ good
_____	___	___ F ___ M	___ home _____ away	___ poor __ average _____ good

Others living in the household			Relationship (e.g., cousin, foster child)	
_____	___	___ F ___ M	_____	___ poor _____ average _____ good
_____	___	___ F ___ M	_____	___ poor _____ average _____ good
_____	___	___ F ___ M	_____	___ poor _____ average _____ good
_____	___	___ F ___ M	_____	___ poor _____ average _____ good

Comments: _____ _____ _____

Family Health History

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

___ Allergies ___ Deafness ___ Muscular Dystrophy

___ Anemia
___ Asthma
___ Bleeding tendency
___ Blindness
___ Cancer
___ Cerebral Palsy
___ Cleft lips
___ Cleft palate
___ Diabetes
___ Glandular problems disorder
___ Heart diseases
___ High blood pressure
___ Kidney disease
___ Mental illness
___ Multiple sclerosis
___ Nervousness
___ Perceptual motor
___ Mental Retardation
___ Seizures
___ Spinal Bifida
___ Suicide
___ Other (specify): _____
_____

Comments re: Family Health: _____

_____

Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurrences of miscarriages or stillborns? _____ Yes _____ No

If Yes, describe: _____

Was the pregnancy with child planned? ____ Yes _____ No

Length of pregnancy: _____

Mother's age at child's birth: _____ Father's age at child's birth: _____

Child number __ of ___ total children.

How many pounds did the mother gain during the pregnancy? _____

While pregnant did the mother smoke? ___ Yes _____ No If Yes, what amount: _____

Did the mother use drugs of alcohol? _____ Yes _____ No If Yes, type/amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication) _____ Yes _____ No

If Yes, describe: _____

Length of labor: _____ Induced: __ Yes ___ No Caesarean? _____ Yes ___ No

Baby's birth weight: _____ Baby's birth length: _____

Describe any physical or emotional complications with the delivery: _____

_____

Describe any complications for the mother or the baby after the birth: _____

_____

Length of hospitalization: Mother: _____ Baby: _____

Infancy/Toddlerhood Check all which apply:

___ Breast fed ___ Milk allergies ___ Vomiting ___ Diarrhea

___ Bottle fed ___ Rashes ___ Colic ___ Constipation

___ Not cuddly ___ Cried often ___ Rarely cried ___ Overactive

___ Resisted solid food ___ Trouble sleeping _____ Irritable when awakened ___ Lethargic

Developmental History Please note the age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____

Took 1st steps: _____ Tied shoelaces: _____

Spoke words: _____ Rode two-wheeled bike: _____

Spoke sentences: _____ Toilet trained: _____

Weaned: _____ Dry during day: _____

Fed self: _____ Dry during night: _____

Compared with others in the family, child's development was: ___ slow ___ average _____ fast

Age for following developments (fill in where applicable)

Began puberty: _____ Menstruation: _____

Voice change: _____ Convulsions: _____

Breast development: _____

Injuries or hospitalization: _____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

_____

_____

Education

Current school: _____ School phone number: _____

Type of school: _____ Public ___ Private _____ Home schooled _____

Other (specify): __

Grade: _____ Teacher: _____ School Counselor: _____

In special education? _____ Yes _____ No If Yes, describe: _____

In gifted program? _____ Yes _____ No If Yes, describe: ____

Has child ever been held back in school? _____ Yes _____ No If Yes, describe: _____

Which subjects does the child enjoy in school? _____

Which subjects does the child dislike in school? _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? ___ Yes _____ No

If Yes, describe: _____

Has the child been tested psychologically? ___ Yes _____ No

If Yes, describe: _____

Check the descriptions which specifically relate to your child.

Feelings about School Work:

___ Anxious ___ Passive ___ Enthusiastic ___ Fearful

___ Eager ___ No expression ___ Bored ___ Rebellious

___ Other (describe): _____

Approach to School Work:

___ Organized ___ Industrious ___ Responsible ___ Interested

___ Self-directed ___ No initiative ___ Refuses ___ Does only what is expected

___ Sloppy ___ Disorganized ___ Cooperative ___ Doesn't complete assignments

___ Other (describe): _____

Performance in School (Parent's Opinion):

___ Satisfactory ___ Underachiever ___ Overachiever

___ Other (describe): _____

Child's Peer Relationships:

___ Spontaneous ___ Follower ___ Leader ___ Difficulty making friends

___ Makes friends easily _____ Long-time friends __ _ Shares easily

___ Other (describe): _____

Who handles responsibility for your child in the following areas?

School: ___ Mother _____ Father ___ Shared _____
Other (specify): ____

Health: ___ Mother _____ Father ___ Shared _____
Other (specify): ____

Problem behavior: _____ Mother ___ Father _____
Shared _____ Other (specify): ____

If the child is involved in a vocational program or works a job, please fill in the following:

What is the child's attitude toward work? ___ Poor ___ Average __ Good
_____ Excellent

Current employer: _____ Position: _____ Hours per week: __

How have the child's grades in school been affected since working? ___ Lower __ Same
_____ Higher

How many previous jobs or placements has the child had? _____

Usual length of employment: _____ Usual reason for leaving: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?

Medical/Physical Health

___ Abortion	___ Hayfever	___ Pneumonia
___ Asthma	___ Heart trouble	___ Polio
___ Blackouts	___ Hepatitis	___ Pregnancy
___ Bronchitis	___ Hives	___ Rheumatic Fever
___ Cerebral Palsy	___ Influenza	___ Scarlet Fever
___ Chicken Pox	___ Lead poisoning	___ Seizures
___ Congenital problems	___ Measles	___ Severe colds
___ Croup	___ Meningitis	___ Severe head injury
___ Diabetes	___ Miscarriage	___ Sexually transmitted disease
___ Diphtheria	___ Multiple sclerosis	___ Thyroid disorders
___ Dizziness	___ Mumps	___ Vision problems
___ Ear aches	___ Muscular Dystrophy	___ Wearing glasses
___ Ear infections	___ Nose bleeds	___ Whooping cough
___ Eczema	___ Other skin rashes	___ Other
___ Encephalitis	___ Paralysis	_____
___ Fevers	___ Pleurisy	Height: _____ Weight:___

Current Physician: _____ Phone: _____

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

Nutrition & Exercise

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	___ / week	_____	___ No ___ Low ___ Med ___ High
Lunch	___ / week	_____	___ No ___ Low ___ Med ___ High
Dinner	___ / week	_____	___ No ___ Low ___ Med ___ High

Snacks ___ / week _____ ___ No ___ Low ___ Med ___ High

Behaviors tied to food (restriction, binge/purge, emotional reactions): _____

_____

Exercise Habits: _____

Most recent examinations

Type of examination	Date of most recent visit	Results
Physical examination	_____	_____
Dental examination	_____	_____
Vision examination	_____	_____
Hearing examination	_____	_____

_____

Current prescribed medications		Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	

Current over-the-counter meds		Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	

Immunization record (check immunizations the child/adolescent has received):

	DPT	Polio		
2 months MMR (Measles, Mumps, Rubella)	___	___	15 months	_____
4 months HBPV (Hib)	___	___	24 months	_____
6 months HepB	___	___	Prior to school	_____
18 months	___	___		
4–5 years	___	___		

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? _____

Yes _____ No

If Yes, describe: _____

_____

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

	Yes	No	When	Where	Reaction or overall experience
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					

Has the child/adolescent experienced death? (friends, family pets, other) _____
Yes _____ No
At what age? ___ If Yes, describe the child's/adolescent's reaction: _____

_____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)
___ Yes ___ No If Yes, describe: _____

_____

Any additional information that you believe would assist us in understanding your child/adolescent?

_____

_____

_____

Any additional information that would assist us in understanding current concerns or problems?

_____

_____

_____

What are your goals for the child's therapy? _____

_____

_____

_____

_____

What family involvement would you like to see in the therapy? _____

_____

Do you believe the child is suicidal at this time? _____ Yes _____ No
If Yes, explain: _____

_____

Behavioral/Emotional

How are problem behaviors generally handled? _____

_____

What are the family's favorite activities? _____

_____

What does the child/adolescent do with unstructured time? _____

_____

To be completed by child/adolescent (13 yrs. & older) separate from parents.

Please check all that apply.

___ Affectionate
___ Aggressive
___ Alcohol problems
___ Angry
___ Anxiety
___ Attachment to dolls
___ Avoid adults
___ Bedwetting
___ Blinking, jerking
___ Bizarre behavior
___ Bullies, threatens
___ Careless, reckless
___ Chest pains
___ Clumsy
___ Confident
___ Cooperative
___ Cyber addiction
___ Defiant
___ Depression
___ Destructive
___ Difficulty speaking
___ Dizziness
___ Drugs dependence
___ Eating disorder
___ Enthusiastic
___ Excessive masturbation
___ Expect failure
___ Fatigue
___ Fearful
___ Frequent injuries
___ Frustrated easily
___ Gambling
___ Generous
___ Hallucinations
___ Head banging
___ Heart problems
___ Hopelessness
___ Hurt animals
___ Imaginary friends
___ Impulsive
___ Irritable
___ Lazy
___ Learning problems
___ Lie frequently
___ Listen to reason
___ Loner
___ Low self-esteem
___ Messy
___ Moody
___ Nightmares
___ Obedient
___ Often sick
___ Oppositional
___ Over active
___ Overweight
___ Panic attacks
___ Phobias
___ Poor appetite
___ Psychiatric problems
___ Quarrels
___ Sad
___ Selfish
___ Separation anxiety
___ Set fires
___ Sexual addiction
___ Sexual acting out
___ Shares
___ Sick often
___ Short attention span
___ Shy, timid
___ Sleeping problems
___ Slow moving
___ Soiling
___ Speech problems
___ Stealing
___ Stomach aches
___ Suicidal threats
___ Suicidal attempts
___ Talk back
___ Teeth grinding
___ Thumb sucking
___ Tics or twitching
___ Unsafe behaviors
___ Unusual thinking
___ Weight loss
___ Withdrawn
___ Worry excessively
___ Other:
_____
_____

Please describe any of the above (or other) concerns: _____

What are your favorite activities? _____