



# SOLID GROUND COUNSELING

409 Plymouth Road, Suite 100  
Plymouth, MI 48170  
734-927-1201

## PERSONAL HISTORY INFORMATION (CHILD/ ADOLESCENT)

***Welcome to Solid Ground Counseling!***

Date: \_\_\_\_\_

The purpose of this form is to get a better understanding of your background and presenting issues. Please note that this information is confidential and, within all legal limits, will not be shared with others.

Child/  
Adolescent  
Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ May we leave a message at these #'s? \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Father's Name: \_\_\_\_\_

Address (if different): \_\_\_\_\_

How were you referred to Solid Ground Counseling? \_\_\_\_\_

In case of emergency, who do we contact? \_\_\_\_\_

Relationship to client: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Address: \_\_\_\_\_  
Number Street City State Zip

Do you have a personal representative, conservator, guardian, or representative payee? \_\_\_\_\_

*If yes, please indicate the type of relationship and their contact below:*

Circle all that apply: Personal Representative Conservator Guardian

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Number Street City State Zip

Phone Number: \_\_\_\_\_

### TREATMENT INFORMATION

Person completing form: \_\_\_\_\_

Relationship to child / adolescent: \_\_\_\_\_

Reason child / adolescent is coming for treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your child / adolescent ever received treatment before? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

How does your child / adolescent feel about treatment at this time? \_\_\_\_\_

\_\_\_\_\_

What would you like to have happen while your child / adolescent is in treatment here?

---

---

If needed, are you willing to participate in services that would help in your child's / adolescent's treatment?

---

### SCHOOL ADJUSTMENT

Name of School: \_\_\_\_\_

Homeroom / Primary Teacher's Name: \_\_\_\_\_

School's Address and Telephone Number: \_\_\_\_\_

Grade: \_\_\_\_\_ Has a grade ever been repeated? \_\_\_\_\_

What kind of grades is your child / adolescent receiving? \_\_\_\_\_

Please describe any difficulties your child / adolescent is experiencing in school.

---

---

---

How would you describe your child's/ adolescent's intellectual functioning?

\_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor

Has your child / adolescent ever been psychologically tested? If yes, explain. \_\_\_\_\_

---

Has your child / adolescent ever had special education? \_\_\_\_\_

---

### PERSONAL ADJUSTMENT

Please check any of the following that are typical of your child / adolescent's behavior:

- |                       |                             |                         |
|-----------------------|-----------------------------|-------------------------|
| Shy _____             | Angry, Defiant _____        | Slow moving _____       |
| Worries _____         | Quarrels _____              | Difficult sleep _____   |
| Moody _____           | Bullies _____               | Sleepwalking _____      |
| Sad, cries _____      | Temper tantrums _____       | Bedwetting _____        |
| Loner _____           | Lies frequently _____       | Soiling _____           |
| Expects failure _____ | Destructive _____           | Poor appetite _____     |
| Selfish _____         | Steals _____                | Weightloss _____        |
| Lazy _____            | Sets fires _____            | Overweight _____        |
| Avoids conflict _____ | Drug/ alcohol use _____     | Often ill _____         |
| Sexual trouble _____  | Frequent headaches _____    | Unusual thinking _____  |
| Police problems _____ | Stomach aches _____         | Bizarre behavior _____  |
| Tics or twitch _____  | Messy _____                 | Blinking, jerking _____ |
| Easygoing _____       | Careless, reckless _____    | Seizures _____          |
| Friendly _____        | Short attention span _____  | Speech problems _____   |
| Enthusiastic _____    | Frequent day dreams _____   | Learning problems _____ |
| Confident _____       | Acts without thinking _____ | Cooperative _____       |
| Overactive _____      | Sloppy hygiene _____        | Generous _____          |
| Clumsy _____          | Frequent injuries _____     | Suicide gestures _____  |
| Suicide Attempt _____ | Psychiatric problems _____  |                         |

Please use this space to explain any of the above.

---

---

---

---

### LEGAL ISSUES

Has the child / adolescent ever been involved with the police or juvenile court system? \_\_\_\_\_  
If yes, please explain.

---

---

Are both parents in agreement with bringing the child / adolescent into treatment? \_\_\_\_\_

Are the parents currently involved in a divorce or custody issue? If yes, please explain. \_\_\_\_\_

Are the parents still married? If no, who has physical and legal custody of the child / adolescent? \_\_\_\_\_

---

A copy of the custody agreement is on file at Solid Ground (required). \_\_\_\_\_ Yes \_\_\_\_\_ No

### CHILD'S / ADOLESCENT'S FAMILY

Is your child / adolescent's immunization current? \_\_\_\_\_ Yes \_\_\_\_\_ No

	Name	Age	Sex	Employment/ Education	Marital Status
Father					
Mother					
Sibling (s)					
Others in home					

### INCOME DATA

Do both parents work? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are there any financial problems? \_\_\_\_\_ Yes \_\_\_\_\_ No

### SOCIAL HISTORY

How does your child / adolescent relate to peers? \_\_\_\_\_  
\_\_\_\_\_

Has your child / adolescent ever worked? \_\_\_\_\_

Describe how your child / adolescent relates to adults. \_\_\_\_\_  
\_\_\_\_\_

With whom does your child socialize? \_\_\_\_\_

Does your child / adolescent isolate him or herself from others? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_

### RELIGIOUS INFORMATION

Religion: \_\_\_\_\_

Were you affiliated with a church as a child/ adolescent? \_\_\_\_\_

Is your child / adolescent affiliated with a church currently? \_\_\_\_\_

Name of Church: \_\_\_\_\_ City: \_\_\_\_\_

Would you like prayer incorporated in therapy sessions? \_\_\_\_\_

### CULTURAL/ ETHNIC INFORMATION

What cultural or ethnic group do you come from? \_\_\_\_\_

Does your child / adolescent closely identify with this group? \_\_\_\_\_

What strengths has he or she acquired from this identity? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### DEVELOPMENTAL HISTORY

(check all that apply)

During pregnancy: Any bleeding? \_\_\_\_\_ High blood pressure? \_\_\_\_\_

Check any that were used during pregnancy: \_\_\_\_\_ Tobacco \_\_\_\_\_ Alcohol  
\_\_\_\_\_ Drugs Explain \_\_\_\_\_

Sickness of the mother? \_\_\_\_\_

Other difficulties? \_\_\_\_\_

Birth: \_\_\_\_\_ Full Term \_\_\_\_\_ Premature

Baby's Weight: \_\_\_\_\_

Type of delivery (breech, cesarean, normal): \_\_\_\_\_

Condition at birth: \_\_\_\_\_

Was oxygen given at birth? \_\_\_\_\_

At what age did your child: Walk alone \_\_\_\_\_ Toilet Train \_\_\_\_\_

Use single words \_\_\_\_\_ Sentences \_\_\_\_\_

Has your child / adolescent had an eye exam? \_\_\_\_\_ Yes \_\_\_\_\_ No

What were the results? \_\_\_\_\_

Has your child / adolescent had a hearing exam? \_\_\_\_\_ Yes \_\_\_\_\_ No

What were the results? \_\_\_\_\_

Has your child / adolescent ever had difficulties regarding speech functioning? If yes, explain.

\_\_\_\_\_ Yes \_\_\_\_\_ No Explain \_\_\_\_\_

Has your child / adolescent ever had convulsions? If yes, explain. \_\_\_\_\_ Yes \_\_\_\_\_ No

Explain \_\_\_\_\_

Has your child / adolescent ever experienced injuries, hospitalizations? If yes, explain. \_\_\_\_\_

Explain \_\_\_\_\_

Was your child / adolescent adopted? If yes, at what age? \_\_\_\_\_ Yes \_\_\_\_\_ No

Age \_\_\_\_\_

Does your child know about his or her adoption? \_\_\_\_\_

**For girls only:** Age at onset of menstrual period: \_\_\_\_\_ Problems? \_\_\_\_\_

Pregnancies? \_\_\_\_\_ Abortions? \_\_\_\_\_

Explain \_\_\_\_\_

**CHILD'S / ADOLESCENT'S PHYSICIAN**

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Results of physical exam: \_\_\_\_\_

Is your child / adolescent currently taking any medications? If yes, what is it (are they)? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent / Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist's Signature & Credentials

\_\_\_\_\_  
Date