LAURA LADEFIAN
COUNSELING

CHILD & ADOLESCENT HISTORY FORM

Child's name: _____ Date of Birth: _____

School: _____ Grade: _____

Parent(s) or Legal Guardian's Name: _____

Marital Status: S M D W Does anyone else share legal custody? Yes No

If yes, please name: _____

Home address: _____

Phone: _____ Email: _____
Do I have permission to leave a voicemail? Yes No

Referred by: _____

Please briefly describe the reason you have initiated counseling for your child: _____
_____
_____
_____

What are your goals for therapy? _____
_____
_____
_____

What are your child's strengths, interests, and hobbies? _____
_____
_____

MEDICAL HISTORY:

Please share any significant notes about your child's prenatal and developmental history:_____
_____
_____

Please share any significant illnesses, injuries, or surgeries your child has had: _____
_____
_____

Primary Care Physician: _____ Date of last visit: _____

Current Medication(s):

Medication	Dose	Prescribing Physician	Purpose

Has your child ever been evaluated by a Psychologist, received treatment from a Psychiatrist or participated in Counseling before? If so, please share dates and any diagnoses and/or medications:_____
_____
_____
_____
_____

Has your child ever been supported by an Occupational Therapist, Speech-Language Pathologist, Executive Function coach, or other related professional? If so, please share dates and presenting concern:_____
_____
_____

Please describe your child's sleep and diet habits that may impact mood and functioning: _____
_____
_____
_____

Any allergies? _____

Any significant family history of illness (incl. mental health)? _____
_____
_____

PSYCHOSOCIAL HISTORY:

Please list names, relationships, and ages of all individuals living in the home with the child: _____
_____
_____
_____

Please describe significant family dynamics including notes on the Parent-Child relationships: _____
_____
_____
_____
_____

Are there any sociocultural factors that you would like me to know about you or your child?: _____
_____
_____

Notes on Family Schedule and Routines: _____
_____
_____

What are you family values around discipline and how does your child respond to your approach: _____
_____
_____
_____

Please describe your child's relationship with technology & social media: _____
_____
_____

Significant Social History or Dynamics: _____
_____
_____

Significant Academic History or Dynamics: _____
_____
_____

Major Life Events (e.g. family changes, adoption, moves, loss, separation): _____
_____
_____
_____

Participation in Organized Activities: _____
_____
_____

Has your child ever experienced any trauma (abuse, neglect, witness to domestic violence, victim of violent crime)? If yes, was there any DFCS or legal system involvement?: _____
_____
_____
_____

CURRENT SYMPTOMS: (Circle all that apply)

Anxiety	Tantrums	Mood Swings	Depression
Anger	Cries Easily	Fears	Panic Attacks
Self-Harm	Irritability	Excessive Worry	Wetting the Bed
Headaches	Peer Difficulties	Startles Easily	Defiant Behavior
Fatigue	Chest Pain	Racing Thoughts	Hyperactivity
Impulsivity	Learning Disability	Loss of Interest	Change in Eating
Change in Academics	Long Periods of Sadness	Change in Toileting Habits	Difficulty Concentrating
Sibling Rivalry	Separation Anxiety	Substance Abuse	Change in Sleep
Intrusive Memories	Developmental Delay	Memory Challenges	Physical Aggression
Recent change In mood	Nausea/ Stomach Aches	Nightmares	Social Withdrawal

Other: _____
_____

Is there any additional information you would like for me to know about your child or your family?
_____
_____
_____
_____

I hereby certify that the content disclosed within these pages is accurate and complete to the best of my knowledge.

_____ _____
Parent/Guardian Signature Date