DATE _____ Trellis Counseling, LLC

PERSONAL HISTORY FORM-MINOR

Client name: _____Age: _____ D.O.B. _____ Gender: M F

Parents' names: _____

If parents are not married, who has legal custody? ___ Mother ___Father ___Other: _____

If parents are not married, explain physical custody arrangements: _____

_____

Primary reason(s) for seeking services:

____ Depression	____ Anxiety	____ Alcohol/drugs	____ Anger management
____ Coping	____ Fear/phobias	____ Behavior problems	____ Family issues/conflict

Other: _____

Please circle behaviors and symptoms that are problematic:

Aggression	Worrying	Hallucinations	Attention Deficit
Anxiety	Heart Palpitations	People avoidant	Trouble concentrating
Depression	Recurring thoughts	Disorientation	Sexual problems
Alcohol problems	Irritability	Cyber addiction	Antisocial behavior
Fatigue	Impulsivity	Speech problems	Sleep problems
Panic attacks	Distractibility	Gambling	Fears/phobias
Anger	Chest pain	Sick often	Self injury/behavior
Hopelessness	Loneliness	Drug problems	Memory problems
Suicidal thoughts	mood swings	Eating issues	withdrawing

Does the minor report feeling suicidal at this time? Yes or No
Does the minor report having a plan for suicide? Yes or No
Please include any additional information that would assist us in understanding your concerns and problems?

_____

_____

Has the minor recently experienced any that follow?

Recent death or birth in the family	Accident, fire, disaster	Separation or divorce
Job loss or change	Arrest or DUI	Major Financial problems
Change in living arrangements	Physical/emotional abuse	Sexual abuse or assault
Thoughts/acts of violence to others	Thoughts/acts of hurting self	Custody issues
Pregnancy, miscarriage, abortion	Diagnosis of major illness	Significant relationship discord

Developmental history

Has there been a history of child abuse? Yes or No If yes, which type: ___ Sexual ___ Physical ___Verbal
Other childhood issues: ___Neglect _____Exposure to trauma _____Inadequate nutrition
Are there any special, unusual, or traumatic circumstances that affected your upbringing? Yes or No
Please explain _____

Social Relationships

Circle how the minor generally gets along with other people:

Affectionate	Aggressive	Avoidant	fight/argue often	Follower
Friendly	Leader	Outgoing	Shy/withdrawn	Submissive

What is the minor's sexual orientation? _____

Is the minor sexually active? Yes or No

Spiritual/Religious

Are you connected with a spiritual or religious group? Please explain_____
Were you raised within a spiritual or religious group? Yes or No
Would you like your spiritual beliefs incorporated into the counseling? Yes or No

Legal

Involved in any active legal cases (traffic, civil, criminal)? Yes or No
If yes, please describe charges _____
Currently on probation or parole? Yes or No
Accusations of any sexual crimes? Yes or No

Education, Employment, Military (circle)

Education: Currently enrolled in school | High school grad/GED | Vocational school
Some College | College Graduate | Masters or Doctorate

Any learning disabilities: Yes or No If yes, please explain _____

Employment: Current employer _____

Fulltime	Part time	Temp	Laid-off	Disabled	Retired	Social Security
Job satisfaction:		poor	good	fair	great	

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, traveling sports, etc.)

_____

_____

Medical/Physical Health

Primary care Doctor _____ phone _____
List any current health conditions/recent health changes: _____
Currently using any prescribed medications: _____

Please circle if there have been any changes in the following:

Sleep patterns	Eating patterns	Behavior	Energy level	Physical activity level
General disposition	Weight	Nervousness/tension		

Others: _____

Chemical use History

Do you use drugs or alcohol? Yes or No

If so, how frequently: [ ] Daily [ ] 2-5 Times per Week [ ] Weekly [ ] Other

How does use affect your life? _____

Has anyone expressed concern about use? Yes or No

Is minor concerned about use? Yes or No

Is there presently or past history of a family member having problems with drugs or alcohol? Yes or No

Consequences experienced because of use? Legal, relational, physical, mental, job, financial

Please explain: _____

_____

Counseling Prior treatment History

Information about client (past and present):

	Yes	No	When	Where
Counseling/Psychiatric Care	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____

Is there a family history of mental illness or substance abuse problems? _____

Please list treatment goals wished to accomplish.

_____

_____

_____

_____

Thank you for your time completing the questionnaire.