

DATE _____

NORTHWINDS COUNSELING SERVICES

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 felling 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Friendly	Leader	Outgoing	Shy/withdrawn	Submissive

Heroin/Opiates	_____	_____	_____	_____	yes	yes
PCP/LSD/Mescaline	_____	_____	_____	_____	yes	yes
Inhalants	_____	_____	_____	_____	yes	yes
Caffeine	_____	_____	_____	_____	yes	yes
Nicotine	_____	_____	_____	_____	yes	yes
Pain killers	_____	_____	_____	_____	yes	yes

Drug of choice: _____

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.