the center for play therapy
Jacqueline Wright, MS MFT

Psychosocial History (Child/Adolescent)

Welcome to The Center for Play Therapy. Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. If possible (and applicable), both parents should complete the form together. Feel free to ask for assistance, if needed. Once the form is reviewed, the therapist will discuss your responses with you.

Child's name: _____ Date of first visit: _____

Completed by: _____ Relationship to child: _____
Cell phone: _____ (May call? Yes No Leave message? Yes No)
Home phone: _____ (May call? Yes No Leave message? Yes No)
Work phone: _____ (May call? Yes No Leave message? Yes No)
Best time and place to call: _____
Email address: _____ (May send or respond to messages? Yes No)
Child's address: _____
Child's gender: Male ____ Female ____ Child's Age: ____ Date of birth: __/__/__
Child's ethnicity: African American ___ Asian ___ Bi-racial ___ Caucasian ___
Hispanic/Latino(a) ___ Native American ___ Other _____
Child's primary language: English ___ Spanish ___ Other _____
Language spoken at home (parent's language): _____

Child's legal guardian (managing conservator): _____
(If the child is not living with both natural parents, both adoptive parents, or only living parent, the office requires a photocopy of the legal document stating custody arrangements, consisting of the cover page, page specifying conservator(s), and signature page. The photocopy should be stapled to this form.)
In case of emergency, contact: Name: _____ Phone: _____

Is your child presently receiving therapy elsewhere? Yes No
(If yes, do not complete this form until you have talked with the therapist.)
Family members receiving services at this office? Yes No
(If yes, name(s)/dates of service.)
_____

School child attends: _____
Current school address & phone: _____
Grade level: _____ Has your child ever been retained? Yes No If yes, grade? _____
Current teacher(s): 1) _____ 2) _____ 3) _____

Current school counselor: _____
Is your child currently on probation? Yes No
Is your child receiving special education or other services? Yes No
(explain) _____
Has your child ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No (If so, we will need your permission in order to communicate with that individual or agency.)
Previous mental health professional/agency: _____
Address: _____ Phone: _____
Dates of service: _____ (beginning – ending)
Has your child been hospitalized for mental health concerns? Yes No
If yes: When? _____ Where? _____

How were you referred to this office? (Check all those that apply):
Counselor/Psychologist/Psychiatrist _____ School personnel _____ Court _____
Minister _____ Self _____ DCFS _____ Newspaper/Magazine ad _____
Brochure _____ Physician _____ Friend or co-worker _____ Relative _____
Internet/Google _____ Psychology Today _____ Other _____

Are you seeking services because your child is a victim of a crime? Yes No
Did it result in legal action? Yes No (If yes, explain) _____

Person responsible for financial arrangements with our clinic: _____
Gross household annual income (including child support payments):
Less than $25,000 _____ $25,001-$35,000 _____ $35,001-$45,000 _____
$45,001-$60,000 _____ $60,001+ _____
How many family members currently reside in your home? _____

Information on Child's Caregiver (1)

Caregiver's name: _____ Date of birth: _____
I am: Biological parent _____ Stepparent _____ Adoptive parent _____ Other _____
Address: _____
Cell phone: _____ (May call? Yes No May leave message? Yes No)
Home phone: _____ (May call? Yes No May leave message? Yes No)
Work phone: _____ (May call? Yes No May leave message? Yes No)
Email address: _____ (May send or respond to messages? Yes No)
Occupation: _____ Employer: _____ How long: _____
Education level: 8th grade or below _____ Trade school/some college _____
Undergraduate degree _____ High school _____ GED _____ Graduate degree _____

History of learning, emotional, or behavioral problems: Yes No
(If yes, please explain) _____
History of alcohol/drug/substance abuse: Yes No
(If yes, please explain) _____

History of family violence: Yes No
(If yes, please explain) _____
History of criminal activity: Yes No
(If yes, please explain) _____

Current living arrangements: Family of origin ___ Single ___ Spouse/Partner ___
Roommate ___ Other _____
Marital status (indicate all that apply and duration of each, ex. 1965-1985):
Never married _____ Currently married _____ Divorced _____ Widowed _____
Deceased _____
Marital history: Number of marriages _____ Number of divorces _____

Information on Child's Caregiver (2)

Caregiver's name: _____ Date of birth: _____
I am: Biological parent _____ Stepparent _____ Adoptive parent _____ Other _____
Address: _____
Cell phone: _____ (May call? Yes No May leave message? Yes No)
Home phone: _____ (May call? Yes No May leave message? Yes No)
Work phone: _____ (May call? Yes No May leave message? Yes No)
Email address: _____ (May send or respond to messages? Yes No)
Occupation: _____ Employer: _____ How long: _____
Education level: 8th grade or below _____ Trade school/some college _____
Undergraduate degree _____ High school _____ GED _____ Graduate degree _____

History of learning, emotional, or behavioral problems: Yes No
(If yes, please explain) _____
History of alcohol/drug/substance abuse: Yes No
(If yes, please explain) _____
History of family violence: Yes No
(If yes, please explain) _____
History of criminal activity: Yes No
(If yes, please explain) _____

Current living arrangements: Family of origin ___ Single ___ Spouse/Partner ___
Roommate ___ Other _____
Marital status (indicate all that apply and duration of each, ex. 1965-1985):
Never married _____ Currently married _____ Divorced _____ Widowed _____
Deceased _____
Marital history: Number of marriages _____ Number of divorces _____

General Information

Child's current household: Adoptive parents _____ Biological dad & stepmom _____
Dad only _____ Biological mom & stepdad _____ Foster family _____
Biological parents _____ Same sex couple _____ Institution _____ Mom only _____
Grandparents _____ Relatives (specify) _____

List by household your child's current family, beginning with the oldest member and include the child:

Primary household (anyone who currently lives with child)
How long in this current living situation: _____

Name	Age	Gender	Relationship to you

Child lives in: House _____ Apartment _____ Duplex _____ Other _____

Secondary household (non-custodial or extended family, if applicable)

Name	Age	Gender	Relationship to you

Child lives in: House _____ Apartment _____ Duplex _____ Other _____

Currently involved in a custody dispute: Yes No (If yes, explain) _____
_____

If divorced, circle the number which best describes your relationship with your ex-spouse.

Hostile		Frustrating		Friendly
1	2	3	4	5

How often does the child see his/her non-custodial parent? _____

Child's Health

Child's primary care physician:

_____ _____

Name Phone

_____

Address

Has your child ever seen a psychiatrist? Yes No
Is your child currently seeing a psychiatrist? Yes No (If yes, list name, address, and phone):

_____ _____

Name Phone

_____

Address

Date of last complete physical: _____
Physical disability: Yes No (If yes, explain) _____
Chronic illness: Yes No (If yes, explain) _____
Terminal illness: Yes No (If yes, explain) _____

Check the following items for a diagnosis or medication that your child is now receiving or has received:

Diagnosis	Current *(list dates)*	Past *(list dates)*	Dr.'s name	Name of med.	Dosage
Depression	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____
Conduct disorder	_____	_____	_____	_____	_____
Anxiety/nervous	_____	_____	_____	_____	_____
Bipolar disorder	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____
Oppositional def.d.	_____	_____	_____	_____	_____
Mood/anger	_____	_____	_____	_____	_____
Tics	_____	_____	_____	_____	_____
Insomnia/sleepless	_____	_____	_____	_____	_____
OCD	_____	_____	_____	_____	_____
Addictions	_____	_____	_____	_____	_____
Seizures	_____	_____	_____	_____	_____
PTSD	_____	_____	_____	_____	_____
Other (specify)	_____	_____	_____	_____	_____

(If you do not know the name and dosage of current medication(s), please bring the medication(s) to your next session.)

What other medication is your child currently taking?

Medication	Dosage	Taken for what reason?

Current Concerns

Circle the item that you see as the most significant issue for your child. **Underline** any additional concerns.

Problems Related to Abuse
Current or past physical abuse
Current or past sexual abuse
Current or past emotional abuse
Current or past neglect
History of abandonment
Suspected sexual abuse
History of family domestic violence
Intentionally hurting animals

Mood-related Concerns
Disturbing memories
Difficulty going to sleep/staying asleep
Nightmares/night terrors
Suicidal ideation
Sadness/depression
Feelings of guild and shame
Excessive worrying
Anxiety
Anger/irritability

Rule-Breaking/Behavior Problems
Aggression toward others
Drug/alcohol use
Truancy
Gang involvement
Running away
Stealing

Academic/School Problems
Learning difficulties
Problems with peers
Problems with teachers
Speech problems

Family Relationship Concerns
Difficulty adjusting to family changes
Discipline concerns
Parent-child relationship problems
Sibling concerns
Divorce/separation
Religious/spiritual concerns

Other Behavioral Concerns
Sexual identity concerns
Inappropriate sexual behavior
Overeating/refusal to eat
Bedwetting or soiling
Hyperactive/inattentive
Fire-setting
Other unusual behaviors or concerns
(Please specify)
_____
_____
_____
_____
_____

Remember to circle the most significant issue.

When did you first become concerned about the main/most significant issue?
_____
How have you attempted before now to deal with this issue? _____
_____
Other treatment your child has received to address any of the concerns indicated above: None _____ Family therapy _____ Group therapy _____
Individual therapy _____ Hospitalization _____ Other _____

History of Trauma/Stressors Related to the Child

(For each of the following items that apply, write in your child's approximate age at the time it occurred):
Chronic illness of family member _____ Death of significant person _____
Domestic violence _____
Family member absent (explain) _____
Family member's disability/major accident/illness _____
Family member emotional problems (explain) _____
Family member suicide (explain) _____
Parents divorced _____ Child separated from parent (how long & when) _____
Death of a pet _____ Difficult medical treatments _____ Natural disaster _____
Sexual assault _____ Victim of trauma (unusual, terrifying experience) _____
Other _____

History of your child having learning, emotional, behavioral problems: Yes No
(If yes, please explain) _____
History of your child having alcohol/drug/substance abuse: Yes No
(If yes, please explain) _____
History of family violence: Yes No
(If yes, please explain) _____
History of criminal activity in the family: Yes No
(If yes, please explain) _____

Has your child been abused (check all that apply):
Physically _____ Emotionally _____ Sexually _____
Has your child been neglected (check all that apply):
Physically _____ Emotionally _____ Sexually _____
School problems (indicate all that apply):
Academic problems (explain) _____
Discipline problems (explain) _____
Social problems (explain) _____
Early language/speech problems (explain) _____
Other _____

History of health/physical problems includes (check all that apply):

Asthma ____	Dizziness ____	Severe PMS ____
Bedwetting ____	Severe headaches ____	Overeating/under ____
Bone/joint/muscle ____	Heart palpitations ____	Shortness of breath ____
Chest pain ____	Hospitalization ____	Sleep problems ____
Chronic illness ____	Major accident ____	Surgeries ____
Develop. delay(s) ____	Major illness ____	Chronic diarrhea ____
Nervous stomach ____	Disability ____	Neurological problem ____

Other _____

Home Atmosphere

Child's current use of computer, TV/DVD, phone/texting (circle the number of hours that best describes use):

Computer (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

TV/DVD (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

Phone/texting (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

What do you enjoy most about this child? _____

_____

_____

_____

What do you find most difficult about this child? _____

_____

_____

_____

Anything else you think we need to know? _____

_____

_____

_____

**Developed by Counseling Program Clinical Services, University of North Texas, Department of Counseling and Higher Education. Adapted by Jacqueline Wright, MS MFT 6.01.2009, rev 8.05.2013*

The Center for Play Therapy, LLC
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