LSUHSC Child and Family Counseling Clinic

Psychosocial History Information

CHILD’S DEMOGRAPHICS

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>Sex: M F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date:</td>
<td>Age: ___</td>
</tr>
</tbody>
</table>

Home Address:

<table>
<thead>
<tr>
<th>Phone (H)</th>
<th>Can we leave a message?</th>
<th>Y N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone (C)</td>
<td>Can we leave a message?</td>
<td>Y N</td>
</tr>
<tr>
<td>Phone (W)</td>
<td>Can we leave a message?</td>
<td>Y N</td>
</tr>
</tbody>
</table>

School: Grade: 

Teacher: Phone: 

School Counselor’s Name: 

Person filling out this form (relationship to child) 

Who referred you? 

Based on the person who referred you/your child for services, do you agree with the referral? Y N 

If no, please explain: 

Is this referral related to any type of legal or court proceedings? Y N 

If yes, please explain: 

PRESENTING ISSUE(S): 

Briefly describe your child’s current difficulties:

How long has child had problem for which you are seeking help?

Please rate the intensity of the problem or concern that you have in reference to your child? (Circle a number) 

1 | 2 | 3 | 4 | 5 

Describe the behaviors of your child, the impact on the: 

Home: 

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School ____________________________________________

Other social environments ____________________________________________

What have you done in an attempt to resolve the problem and what results and changes have developed in response to the problem over time? Please explain in detail: ____________________________________________

Has your child been seen previously for psychological or psychiatric consultation?  
___ Yes ___ No  Name of Professional: _____________________________ Dates of Service: ________
For what purpose(s): ____________________________________________

Has your child been seen previously for services including speech, occupational, physical therapy, etc?  
___ Yes ___ No  Name of Professional: _____________________________ Dates of Service: ________
For what purpose(s): ____________________________________________

Is your child adopted? _____ Yes _____ No  Date of adoption: ____________________________

**FAMILY HISTORY**

Mother’s Name: ____________________________ Age: ________
Occupation: ____________________________ Phone #: ____________________________

Father’s Name: ____________________________ Age: ________
Occupation: ____________________________ Phone#: ____________________________

Step Parent’s Name: _________________________ Age: ________
Occupation: ____________________________ Phone#: ____________________________

Name: ____________________________ Age: ________
Occupant: ____________________________ Phone#: ____________________________

Marital Status of Parents: ____________________________

If parents are separated or divorced, how old was child when the separation occurred? ________

Please describe events which led up to the divorce and events that your child was exposed to (include arguments, fighting, violence if applicable, etc):

__________________________________________

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Which adult does your child live with?  
How long has this current situation been?  
Is your child happy/content with this situation?  
Why?  
Whom is your child closer with (parent)  

Who is financially responsible for this account?  
Name:  
Address:  
Relationship to Client:  
Address  
Email:  
SSN:  
DOB:  
Work Phone:  
Home Phone:  
Cell Phone:  

Family Constellation: (List all people living in household. Include all family members that have frequent contact with child (i.e., weekly, and bi-weekly) such as maternal grandmother, half siblings, stepmother, etc.)  
<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Child</th>
<th>Age</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Describe your child’s daily and weekly routine:  

What kind of physical exercise does your child get?  
What kind of “down” (i.e., no physical activity, TV, Screen time) time does your child get? How long?  

How much caffeine does your child consumer each day?  

Is your child’s eating restricted in any way? How? Why?  

Bedtime  
Wake-up Time  
Hours of Sleep/night  

Difficulty with Siblings?  

Method of Discipline Currently Used (include both caregivers):  

Who is the main disciplinarian at home?  

Do both parents discipline similarly? Differently?  

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Have there been any recent changes in the family system (i.e., change in home location, major events, significant losses, etc.)

Check the activities in which your child participates with the family:

- Movies
- Meals
- Conversations
- Visits with Relatives
- Church
- Games
- Sports
- Trips
- TV
- Other (explain)

What do you enjoy most about this child?

What do you find most difficult about raising this child?

What would you like for your child to be when he/she grows up?

What level of education do you hope your child will complete?

Place a check next to any illness or condition that any member of the immediate family has had. When you check an item, please note the member’s relationship to the child.

- Alcoholism
- Cancer
- Diabetes
- Heart Trouble
- Other
- Nervous or Psychological problems
- Depression
- Suicide Attempt

Please check any past, present, or impending special problems in your family:

- Divorce
- Serious illness
- Legal problems
- deaths
- Frequent relocations
- Psychiatric disorder
- Eating disorders
- New children
- Debilitating injuries/disabilities
- Physical/sexual abuse
- Attempted/completed suicide
- Alcohol/drugs
- Financial crisis
- Marital strifes

PLEASE ANSWER FOR BOTH CAREGIVERS IN THIS SECTION:

Have you personally experienced significant family abuse? 

Have you personally experienced legal problems?

Did you experience learning problems in school?

In general how happy or adjusted were you growing up?

How much is your immediate family a source of emotional support for you?

Who in your family do you feel closest to?

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Most distant from? __________________________  In most conflict with? __________________________

**EDUCATIONAL HISTORY**
Has your child had problems in school? Describe briefly.

________________________________________________________________________________________

________________________________________________________________________________________

Has your child repeated any grades? Describe briefly.

________________________________________________________________________________________

________________________________________________________________________________________

Does your child have many friends (In/Out of School)? Who are they?

________________________________________________________________________________________

________________________________________________________________________________________

Does your child have difficulty making or keeping friends?

________________________________________________________________________________________

________________________________________________________________________________________

Has your child been tested for learning disabilities? Special Education/Support Services?

________________________________________________________________________________________

________________________________________________________________________________________

Please check where appropriate:

_____ Has difficulty with reading

_____ Has difficulty with spelling

_____ Other subjects:

_____ Does not like school

_____ Has difficulty with math

_____ Has difficulty with writing

PSYCHIATRIC HISTORY
Place an (X) for each symptom that applies: (please be prepared to explain during the intake)

_____ Suicidal thoughts  _____ Homicidal thoughts  _____ Depression/sadness  _____ Anxiety/nervousness

_____ Recurrent Intrusive Thoughts  _____ Nightmares  _____ Loss of appetite  _____ Weight Loss  _____ Weight Gain

_____ Apathy  _____ Recurrent/intrusive disturbing recollections or dreams  _____ Overeating

_____ Overwhelming need to perform certain behaviors/rituals  _____ Excessive fears or phobias  _____ Dependent

_____ Significant concerns with physical problems  _____ Difficulty sleeping  _____ Poor frustration tolerance

_____ Explosive anger  _____ Fatigue  _____ Rapid mood changes  _____ Loss of interest in almost all activities

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Euphoria (feel on top of the world)  Feeling worthless  Racing thoughts
Feelings of hopelessness
Decreased need for sleep  Poor self esteem  Aggressive  Visual or auditory hallucinations
Anorexia or Bulimia  Stomach aches  Unmotivated  Bizarre behavior
Shy and withdrawn  Quiet  Self-mutilates  Resists change  Self-stimulates
Wetting bed or clothes  Exhibits sexually inappropriate behavior  Bowel movements in underwear
Risk-taking  Emotional  Is cruel to other people  Immature  Swears a lot  Is very fidgety
Steals things without people knowing on several occasions  Can't remain seated  Firesetting
Often runs away from home and stays away overnight  Can't wait his/her turn when playing with others
Easily lies to others  Answers before s/he hears the whole question  Starts Fight With Others
Rarely follows other's instructions  Doesn't go to school  Destroys other people's property
Breaks into other people's property  Is cruel to animals  When fighting, has used a weapon
Other unusual behavior:

SOCIAL AND BEHAVIOR CHECKLIST

____ Has difficulty with speech  ____ Has frequent tantrums
____ Has difficulty with hearing  ____ Has frequent nightmares
____ Has difficulty with language  ____ Has trouble sleeping (describe): __________
____ Has difficulty with vision  ________
____ Has difficulty with coordination  ____ Rocks back and forth
____ Prefers to be alone  ________
____ Does not get along well with siblings  ________
____ Is aggressive  ________
____ Is shy or timid  ________
____ Is more interested in things than in other people  ________
____ Engages in behavior that could be dangerous to self or others (describe)
____ Has poor bowel control (soils self)  ________
____ Is much too active  ________
____ Is clumsy  ________
____ Has blank spells  ________
____ Is impulsive  ________
____ Shows daredevil behavior  ________
____ Has special fears, habits, etc  ________
____ Bites nails  ________
____ Wets bed  ________
____ Sucks thumb  ________

OTHER:

DEVELOPMENTAL HISTORY

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The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don’t remember the age at which the behavior occurred, please write a question mark.

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Age</th>
<th>Behavior</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Showed response to mother</td>
<td></td>
<td>Put several words together</td>
<td></td>
</tr>
<tr>
<td>Rolled over</td>
<td></td>
<td>Dressed self</td>
<td></td>
</tr>
<tr>
<td>Sat alone</td>
<td></td>
<td>Became toilet trained</td>
<td></td>
</tr>
<tr>
<td>Crawled</td>
<td></td>
<td>Stayed dry at night</td>
<td></td>
</tr>
<tr>
<td>Walked alone</td>
<td></td>
<td>Fed self</td>
<td></td>
</tr>
<tr>
<td>Babbled</td>
<td></td>
<td>Rode tricycle</td>
<td></td>
</tr>
<tr>
<td>Spoke first word</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Early Childhood**

<table>
<thead>
<tr>
<th>Child walked</th>
<th>Child spoke words</th>
<th>Child spoke sentence</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 12 months</td>
<td>&lt; 12 months</td>
<td>&lt; 12 months</td>
</tr>
<tr>
<td>12 – 24 months</td>
<td>12-24 months</td>
<td>12-24 months</td>
</tr>
<tr>
<td>24-36 months</td>
<td>24-36 months</td>
<td>24-36 months</td>
</tr>
<tr>
<td>&gt; months</td>
<td>&gt; months</td>
<td>&gt; months</td>
</tr>
<tr>
<td>has never walked</td>
<td>has never words</td>
<td>has never spoken sentences</td>
</tr>
</tbody>
</table>

During pregnancy, was mother on medication? Yes ____ No
If yes, what kind?

During pregnancy, did mother smoke? Yes ____ No
If yes, how many cigarettes each day?

During pregnancy, did mother drink alcoholic beverages? Yes ____ No
If yes, what did she drink and how often?

During pregnancy, did mother use drugs? Yes ____ No
If yes, what kind and how often?

Were forceps used during delivery? Yes ____ No
Was a Caesarean section performed? Yes ____ No
If yes, for what reason?

Was the child premature? Yes ____ No
If so, by how many months?

What was the child’s birth weight?

Were there any birth defects or complications? Yes ____ No
If yes, please describe:

Were there any feeding problems? Yes ____ No
If yes, please describe:

Were there any sleeping problems? Yes ____ No
If yes, please describe:

As an infant was the child quiet? Yes ____ No
As an infant, did the child like to be held? Yes ____ No
As an infant, was the child alert? Yes ____ No
Were there any special problems in the growth and development of the child during the first few years? Yes ____ No
If yes, please describe:

Child first trained for urination
Child first trained for bowels

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<table>
<thead>
<tr>
<th>Age Group</th>
<th>&lt;12 months</th>
<th>12-36 months</th>
<th>3-5 years</th>
<th>&gt; 5 years</th>
<th>Not yet trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Since initial toilet training:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>frequent wetting during day</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>frequent wetting during night</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>frequent soiling during day</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>frequent soiling during night</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Puberty**

Onset of puberty (breast development, menstruation, pubic hair, facial hair):

<table>
<thead>
<tr>
<th>Age Group</th>
<th>&lt; 10 years</th>
<th>10-12 years</th>
<th>&gt; 12-14 years</th>
<th>&gt; 16 years</th>
<th>no development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puberty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEDICAL HISTORY**

**Allergies:**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Describe:</th>
</tr>
</thead>
</table>

**Serious Accidents:**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Describe:</th>
</tr>
</thead>
</table>

**Head Injury with Loss of Consciousness:**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Describe:</th>
</tr>
</thead>
</table>

**Serious Illness:**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Describe:</th>
</tr>
</thead>
</table>

**Chronic Illness:**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Describe:</th>
</tr>
</thead>
</table>

**Hospitalizations:**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Length of hospitalization:</th>
</tr>
</thead>
</table>

**Condition for which hospitalized:**

<table>
<thead>
<tr>
<th>Child’s Age:</th>
</tr>
</thead>
</table>

**Other Medical Problems:**

<table>
<thead>
<tr>
<th>Present Medications:</th>
</tr>
</thead>
</table>

**Type:**

| Type: |

**Dose:**

| Dose: |

**Frequency:**

| Frequency: |

**Pediatrician Name:**

| Contact #: |

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**LEGAL HISTORY**

Child Abuse/Domestic Violence

<table>
<thead>
<tr>
<th>Current:</th>
<th>Physical</th>
<th>Sexual</th>
<th>Emotional</th>
<th>Neglect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnessed Violence</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Perpetrator(s)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Relationship to Child</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Victim(s)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Relationship to Child</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Description of Incidents that Occurred:

<table>
<thead>
<tr>
<th>Was there a report filed?</th>
<th>Yes [ ] No [ ]</th>
<th>When: [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the Department of Human Services Involved?</td>
<td>Yes [ ] No [ ]</td>
<td></td>
</tr>
<tr>
<td>What was the DHS response &amp; Long Term Plan?</td>
<td>[ ]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Was a Forensic Interview Taken?</th>
<th>Yes [ ] No [ ]</th>
<th>Date: [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviewer:</td>
<td>[ ]</td>
<td>Phone: [ ]</td>
</tr>
<tr>
<td>Impending Court Appearance: Yes [ ] No [ ]</td>
<td>Date: [ ]</td>
<td></td>
</tr>
<tr>
<td>Purpose:</td>
<td>[ ]</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Domestic Violence Shelter?</th>
<th>Yes [ ] No [ ]</th>
<th>Describe: [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caseworker:</td>
<td>[ ]</td>
<td>Phone: [ ]</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Orders of Protection: Yes [ ] No [ ]</th>
<th>Describe: [ ]</th>
</tr>
</thead>
</table>

**Previous Abuse/Violence:**

<table>
<thead>
<tr>
<th>Perpetrator(s)</th>
<th>Physical</th>
<th>Sexual</th>
<th>Emotional</th>
<th>Neglect</th>
<th>Witnessed Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to Child</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Victims(s)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Relationship to Child</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Describe:

<table>
<thead>
<tr>
<th>Was there a Report Filed: Yes [ ] No [ ]</th>
<th>Date: [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the Department of Human Services Involved? Yes [ ] No [ ]</td>
<td></td>
</tr>
<tr>
<td>Caseworker:</td>
<td>[ ]</td>
</tr>
<tr>
<td>DHS Response &amp; Long Term Plan</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Was there a Forensic Interview Done: Yes [ ] No [ ]</th>
<th>Describe: [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was there a Court Appearance</td>
<td>Yes [ ] No [ ]</td>
</tr>
</tbody>
</table>

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Domestic Violence Shelter: Yes No Describe: __________________________

Caseworker __________________________ Phone ______________

Order of Protection: Yes ___ No ___ Describe __________________________

Intergenerational History of Child Abuse/Domestic Violence? Yes ___ No ___

Describe: _________________________________________________________

Divorce Yes ___ No ___ Describe: _________________________________

Current Custody Proceedings: Yes ___ No ___ Describe: __________________

Past Custody Proceedings: Yes ___ No ___ Describe: _____________________

Law Enforcement System (For all persons mentioned be as specific as possible about relationship to child)

Contact(s) NOT Leading to Arrest: Yes ___ No ___ Describe: ________________

Arrest(s) NOT Leading to Arrest: Yes ___ No ___ Describe: ________________

Juvenile Offender System (For all persons mentioned be as specific as possible about relationship to child)

Arrests for Statutory Violation(s): Yes ___ No ___ Description/Outcome ______________

Arrests for Misdemeanor(s): Yes ___ No ___ Description/Outcome __________

OTHER INFORMATION

What are your child’s favorite activities?

1. __________________________ 2. __________________________ 3. ________________________

4. __________________________ 5. __________________________ 6. ________________________

What activities would your child like to engage in more often than he/she does at present?

1. __________________________ 2. __________________________ 3. ________________________

What activities does your child like least?

1. __________________________ 2. __________________________ 3. ________________________

Has your child ever been in trouble with the law? Yes ___ No ___

If yes, describe: ______________________________________________________
CAREGIVER'S EXPECTATIONS OF SERVICES:

What do you expect from receiving services for your child? For yourself? Explain.

What are your goals for your child? For yourself? Explain.

How long do you believe the therapy should take for your child's presenting issue(s) to be resolved? Explain.

What is your role as your child's caregiver(s)? Please describe for both caregivers.

What stressors are evident in your lives?

What do you believe the role of the therapist is who will be providing services to your child?

Is there any other information that you think may help us in working with your child?