AZIMUTH
Counseling & Therapeutic Services, Inc.

Thank you for your interest in our services here at Azimuth Counseling and Therapeutic Services.

If you have not received a call from our office informing of your ability to schedule with one of our clinicians, then please do not fill in these forms and instead give us a call in order to do an intake questionnaire with our office over the phone.

If you have been told from our office that you can schedule with one of our therapists, please read the following pages and have any children under 18 fill out, with help from a parent or guardian as needed, the following forms and return them to our office. If you are coming in for family counseling, all family members over 18 must also fill out the "Adult Personal History" forms on our website. In order to keep your information confidential please *do not* email the forms back to us! You may fax, mail, or hand deliver them to our office.

We look forward to serving you. Please give us a call if you have any questions that we can help you with.

Azimuth Counseling & Therapeutic Services

8 Essex Way, Suite 101, Essex, VT 05452
Phone (802) 288-1001
Fax (802) 288-1077

ACTS
Family, Adolescent and Children History Form

Revised 7/11/16

Client's name: _____ Date: _____/_____/_____

Gender: ___ F ___ M Age: _____ Grade in school: _____

Date of birth: _____ Location of Birth: _____ Ethnicity _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: ____ ZIP: _____

Phone (home): _____ (cell): _____ (work): _____ Ext: _____

If you need any more space for any of the following questions, please use the back of the sheet.

Primary reason(s) for seeking services:

- ❑ Anger management
- ❑ Alcohol/drugs
- ❑ Sleeping problems
- ❑ Mental confusion
- ❑ Eating disorder
- ❑ Anxiety
- ❑ Hyperactivity
- ❑ Addictive behaviors
- ❑ Sexual concerns
- ❑ Fear/phobias
- ❑ Coping
- ❑ Depression
- ❑ Other mental health concerns (specify): _____

_____

Family History

Parents

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

If Yes, who has legal custody? _____

Were the child's parents ever married? ____ Yes ____ No

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling?

____ Yes ____ No If Yes, describe: _____

Client's Parent

Name: _____ Age: _____ Occupation: _____ ____ FT ____ PT

Where employed: _____ Work phone: _____ Ext: _____

Mother's education: _____

Is the child currently living with mother? ____ Yes ____ No

____ Natural parent ____ Step-parent ____ Adoptive parent ____ Foster home _____

Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the mother? ____Yes ____ No

If Yes, please explain: _____

How is the child disciplined by the mother? _____

For what reasons is the child disciplined by the mother? _____

Client's Parent

Name: _____ Age: _____ Occupation: _____ ____ FT ____ PT

Where employed: _____ Work phone: _____ Ext: _____

Father's education: _____

Is the child currently living with father? ____ Yes ____ No

____ Natural parent ____ Step-parent ____ Adoptive parent ____ Foster home _____

Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the father? ____Yes ____ No

If Yes, please explain: _____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

Client's Siblings and Others Who Live in the Household

Name of Siblings	**Age**	**Gender**	**Lives**	**Quality of relationship with the client**
		❑ **F** ❑ **M**	❑ **home** ❑ **away**	❑**poor** ❑**average** ❑**good**
		❑ **F** ❑ **M**	❑ **home** ❑ **away**	❑**poor** ❑**average** ❑**good**
		❑ **F** ❑ **M**	❑ **home** ❑ **away**	❑**poor** ❑**average** ❑**good**
		❑ **F** ❑ **M**	❑ **home** ❑ **away**	❑**poor** ❑**average** ❑**good**
Others living in household	**Age**	**Gender**	**Relationship** (aunt, uncle, cousin, foster child, etc)	**Quality of relationship with the client**
		❑ **F** ❑ **M**		❑**poor** ❑**average** ❑**good**
		❑ **F** ❑ **M**		❑**poor** ❑**average** ❑**good**
		❑ **F** ❑ **M**		❑**poor** ❑**average** ❑**good**
		❑ **F** ❑ **M**		❑**poor** ❑**average** ❑**good**
Comments				

Family Health History

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

- ❑ Allergies
- ❑ Anemia
- ❑ Asthma
- ❑ Bleeding tendency
- ❑ Blindness
- ❑ Cancer
- ❑ Cerebral Palsy
- ❑ Cleft lips
- ❑ Cleft palate
- ❑ Deafness
- ❑ Diabetes
- ❑ Glandular problems
- ❑ Heart diseases
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Mental illness
- ❑ Migraines
- ❑ Multiple Sclerosis
- ❑ Muscular Dystrophy
- ❑ Nervousness
- ❑ Perceptual motor disorder
- ❑ Mental Retardation
- ❑ Seizures
- ❑ Spinal Bifida
- ❑ Suicide
- ❑ Other (specify) _____

Comments re: Family Health _____

_____

Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurrences of miscarriage or stillborn? ____ Yes ____ No

If Yes, describe: _____

Was the pregnancy with child planned? ____ Yes ____ No Length of pregnancy: _____

Mother's age at child's birth: _____ Father's age at child's birth: _____

Child number _____ of _____ total children.

How many pounds did the mother gain during the pregnancy? _____

While pregnant did the mother smoke? ____ Yes ____ No If Yes, what amount: _____

Did the mother use drugs of alcohol? ____ Yes ____ No If Yes, type/amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication) ____ Yes ____ No If Yes, describe: _____

Length of labor: _____ Induced: ____ Yes ____ No Caesarean? ____ Yes ____ No

Baby's birth weight: _____ Baby's birth length: _____

Describe any physical or emotional complications with the delivery: _____

_____

Describe any complications for the mother or the baby after the birth: _____

_____

Length of hospitalization: Mother: _____ Baby: _____

Infancy/Toddlerhood Check all which apply:

- ❑ Breast fed
- ❑ Bottle fed
- ❑ Not cuddly
- ❑ Resisted solid food
- ❑ Milk allergies
- ❑ Rashes
- ❑ Cried often
- ❑ Trouble sleeping
- ❑ Vomiting
- ❑ Colic
- ❑ Rarely cried
- ❑ Irritable when awakened
- ❑ Diarrhea
- ❑ Constipation
- ❑ Overactive
- ❑ Lethargic

Developmental History Please note the age at which the following behaviors took place:

Sat alone: _____ Took 1st steps: _____ Weaned: _____
Spoke words: _____ Spoke sentences: _____
Toilet trained: _____ Dry during day: _____ Dry during night: _____
Fed self: _____ Dressed self: _____ Tied shoelaces: _____
Rode two-wheeled bike: _____
Compared with others in the family, child's development was: ____ slow ____ average ____ fast

Age for following developments (fill in where applicable)
Began puberty: _____ Breast development: _____ Menstruation: _____ Voice change: _____
Convulsions: _____ Injuries or hospitalization: _____
Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)
_____
_____

Education

Current school: _____ School phone number: _____
Type of school: ____ Public ____ Private ____ Home schooled ____ Other (specify): _____
Grade: _____ Teacher: _____ School Counselor: _____
In special education? ____ Yes ____ No If Yes, describe: _____
In gifted program? ____ Yes ____ No If Yes, describe: _____
Has child ever been held back in school? ____ Yes ____ No If Yes, describe: _____
Which subjects does the child enjoy in school? _____
Which subjects does the child dislike in school? _____
What grades does the child usually receive in school? _____
Have there been any recent changes in the child's grades? ____ Yes ____ No
If Yes, describe: _____
Has the child been tested psychologically? ____ Yes ____ No
If Yes, describe: _____
Check the descriptions which specifically relate to your child.

Feelings about School Work:

❑ Anxious ❑ Passive ❑ Fearful ❑ Bored
❑ Eager ❑ Enthusiastic ❑ No expression ❑ Rebellious
❑ Other (describe): _____

Approach to School Work:

- ❑ Organized
- ❑ Self-directed
- ❑ Industrious
- ❑ Responsible
- ❑ Interested
- ❑ Cooperative
- ❑ Disorganized
- ❑ Does only what is expected
- ❑ Doesn't complete assignments
- ❑ Sloppy
- ❑ No initiative
- ❑ Refuses

❑ Other (describe): _____

Performance in School (Parent's Opinion): ____ Satisfactory ____ Underachiever ____ Overachiever ____ Other (describe): _____

Child's Peer Relationships: ____ Spontaneous ____ Follower ____Leader ____ Difficulty making friends ____ Makes friends easily ____ Long-time friends ____ Shares easily

____ Other (describe): _____

Who handles responsibility for your child in the following areas?

School: ____ Parent ____ Parent ____ Shared ____ Other (specify): _____
Health: ____ Parent ____ Parent ____ Shared ____ Other (specify): _____
Problem behavior: ____ Parent ____ Parent ____ Shared ____ Other (specify): _____

If the child is involved in a vocational program or works a job, please fill in the following:
What is the child's attitude toward work? ____ Poor ____ Average ____ Good ____ Excellent
Current employer: _____ Position: _____ Hours per week: _____
How have the child's grades in school been affected since working? ____Lower ____ Same ____ Higher
How many previous jobs or placements has the child had? _____
Usual length of employment: _____ Usual reason for leaving: _____

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, school activities, scouts, etc.)

Activity	How often now?	How often in the past?

Medical/Physical Health

- ❑ Abortion
- ❑ Asthma
- ❑ Blackouts
- ❑ Bronchitis
- ❑ Cerebral Palsy
- ❑ Chicken Pox
- ❑ Congenital problems
- ❑ Croup
- ❑ Diabetes
- ❑ Diphtheria
- ❑ Dizziness
- ❑ Ear aches
- ❑ Ear infections
- ❑ Eczema
- ❑ Encephalitis
- ❑ Fevers
- ❑ Hay fever
- ❑ Heart trouble
- ❑ Hepatitis
- ❑ Hives
- ❑ Influenza
- ❑ Lead poisoning
- ❑ Measles
- ❑ Meningitis
- ❑ Miscarriage
- ❑ Multiple sclerosis
- ❑ Mumps
- ❑ Muscular Dystrophy
- ❑ Nose bleeds
- ❑ Other skin rashes
- ❑ Paralysis
- ❑ Pleurisy
- ❑ Pneumonia
- ❑ Polio
- ❑ Pregnancy
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Seizures
- ❑ Severe colds
- ❑ Severe head injury
- ❑ Sexually transmitted disease
- ❑ Thyroid disorders
- ❑ Vision problems
- ❑ Wearing glasses
- ❑ Whooping cough

❑ Other _____

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

Nutrition

Meal	How Often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	**/week**		❑ **No** ❑ **Low** ❑ **Med** ❑ **High**
Lunch	**/week**		❑ **No** ❑ **Low** ❑ **Med** ❑ **High**
Dinner	**/week**		❑ **No** ❑ **Low** ❑ **Med** ❑ **High**
Snack	**/week**		❑ **No** ❑ **Low** ❑ **Med** ❑ **High**
Comments			

Most recent examinations

Type of examination	Date of most recent visit	Results
Physical examination		
Dental examination		
Vision examination		
Hearing examination		

Current prescribed medications

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter (OTC) medications

Current OTC medications	Dose	Dates	Purpose	Side effects

Immunization record (check immunizations the child/adolescent has received):

	DPT	Polio		Yes
2 months (Measles, Mumps, Rubella)			15 months - MMR	
4 months (Hib)			24 months - HBPV	
6 months				
18 months			Prior to school - HepB	
4 – 5 years				

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? ____ Yes ____ No

If Yes, describe: _____

_____

Counseling/Prior Treatment History

Information about child/adolescent (past and present)	Yes	No	When	Where	Reaction or overall experience
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					

Behavioral/Emotional

Please check any of the following that are typical for your child:

- ❑ Affectionate
- ❑ Aggressive
- ❑ Alcohol problems
- ❑ Angry
- ❑ Anxiety
- ❑ Attachment to dolls
- ❑ Avoids adults
- ❑ Bedwetting
- ❑ Blinking, jerking
- ❑ Bizarre behavior
- ❑ Bullies, threatens
- ❑ Careless, reckless
- ❑ Chest pains
- ❑ Clumsy
- ❑ Confident
- ❑ Cooperative
- ❑ Cyber addiction
- ❑ Defiant
- ❑ Depression
- ❑ Destructive
- ❑ Difficulty speaking
- ❑ Dizziness
- ❑ Drugs dependence
- ❑ Eating disorder
- ❑ Enthusiastic
- ❑ Excessive masturbation
- ❑ Expects failure
- ❑ Fatigue
- ❑ Fearful
- ❑ Frequent injuries
- ❑ Frustrated easily
- ❑ Gambling
- ❑ Generous
- ❑ Hallucinations
- ❑ Head banging
- ❑ Heart problems
- ❑ Hopelessness
- ❑ Hurts animals
- ❑ Imaginary friends
- ❑ Impulsive
- ❑ Irritable
- ❑ Lazy
- ❑ Learning problems
- ❑ Lies frequently
- ❑ Listens to reason
- ❑ Loner
- ❑ Low self-esteem
- ❑ Messy
- ❑ Moody
- ❑ Nightmares
- ❑ Obedient
- ❑ Often sick
- ❑ Oppositional
- ❑ Over active
- ❑ Overweight
- ❑ Panic attacks
- ❑ Phobias
- ❑ Poor appetite
- ❑ Psychiatric problems
- ❑ Quarrels
- ❑ Sad
- ❑ Selfish
- ❑ Separation anxiety
- ❑ Sets fires
- ❑ Sexual addiction
- ❑ Sexual acting out
- ❑ Shares
- ❑ Sick often
- ❑ Short attention span
- ❑ Shy, timid
- ❑ Sleeping problems
- ❑ Slow moving
- ❑ Soiling
- ❑ Speech problems
- ❑ Steals
- ❑ Stomach aches
- ❑ Suicidal threats
- ❑ Suicidal attempts
- ❑ Talks back
- ❑ Teeth grinding
- ❑ Thumb sucking
- ❑ Tics or twitching
- ❑ Unsafe behaviors
- ❑ Unusual thinking
- ❑ Weight loss
- ❑ Withdrawn
- ❑ Worries excessively
- ❑ Other _____

Please describe any of the above (or other) concerns: _____

_____

How are problem behaviors generally handled? _____

_____

What are the family's favorite activities? _____

_____

What does the child/adolescent do with unstructured time? _____

_____

Has the child/adolescent experienced death? (friends, family pets, other) ____ Yes ____ No At what age? _____

If Yes, describe the child's/adolescent's reaction: _____

_____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.) ____ Yes ____ No

If Yes, describe: _____

_____

Any additional information that you believe would assist us in understanding your child/adolescent?

_____

_____

_____

Any additional information that would assist us in understanding current concerns or problems?

_____

_____

_____

What are your goals for the child's therapy? _____

_____

What family involvement would you like to see in the therapy? _____

_____

Do you believe the child is suicidal at this time? ____Yes ____ No

If Yes, explain: _____

_____

For Staff Use

Therapist's comments: _____
_____
_____

Therapist's signature _____ Date: _____ / _____ / _____

Job Title/Credentials _____

Supervisor's comment: _____
_____

Physical exam: ____Required ____ Not required

Supervisor's signature/credentials: _____ Date: _____/ _____ / _____
(Certifies case assignment, level of care and need for exam)