CHILD/ADOLESCENT CLIENT HISTORY

Print

IDENTIFYING INFORMATION

CLIENT NAME: _____ AGE: _____ RACE: _____ SEX: _____

OTHERS IN HOUSE: _____ Parents _____Friend _____ Children _____Siblings _____ Others

Referred By: _____

PERSON COMPLETING THIS FORM (if not the client):

Name: _____ Relationship to client: _____

CURRENT CONCERNS:
Why is the client seeking treatment? _____

_____

Check any of the following behaviors that have recently applied to the client:

☐ Change in sleeping patterns	☐ Agitation/ being upset	☐ Relationship difficulties
☐ Change in eating patterns	☐ Phobias/ fears/ anxiety	☐ Alcohol and/or Drug use
☐ Withdrawal, isolation	☐ Temper outbursts/ Aggression	☐ Tobacco Use
☐ Suicide attempt	☐ Depression	☐ Psychological Testing
☐ Suicidal thoughts	☐ Difficulty in concentration	☐ Other
☐ Hurting self or others	☐ Unstable moods	

HISTORY OF TREATMENT

Has the client/family ever received counseling for emotional or substance abuse problems? ☐ Yes ☐ No

Explain if yes: _____

_____

Problem treated for: _____

Provider: _____ When treated? _____

Problem treated for: _____

Provider: _____ When treated? _____

FAMILY HISTORY

Father's name: _____ Age: ____ Health: _____ Occupation: _____

Home phone # _____ Cell #:_____ Work #:_____

Mother's name: _____ Age: ____ Health: _____ Occupation: _____

Home phone # _____ Cell #_____ Work #:_____

Name(s) and age(s) of Sibling(s):_____

Any significant details about family members? _____

Any family history of mental health treatment? _____

Any significant individuals (other than family) in the home or client's background? _____

Significant life events (include births, deaths, moves, traumatic events): _____

PARENTAL MARITAL HISTORY

Previously married? _____ If yes, please give name of ex-spouse and date(s) of previous marriage: _____

History of marital problems: _____

_____

Names, ages, significant information about children/stepchildren: _____

_____

DEVELOPMENTAL HISTORY

Complications during pregnancy and/or delivery? ☐ Yes ☐ No

Clarify is yes: _____

Developmental milestones: (KEY: Mark "E" for Early; "A" for Age-appropriate; "D" for Delayed)

Sitting alone E-Early

Speaking sentences A-Age Appropriate

Speaking words D-Delayed

Walking, crawling D-Delayed

Toilet training D-Delayed

MEDICAL HISTORY

Are there concerns regarding medical treatment that the client is currently receiving or has recently received? ☐ Yes ☐ No

Explain if yes: _____

Please list all medications: _____

Name of prescribing doctor:_____

Please list any significant medical problems for other members of the family: _____

_____

Has the client ever been physically or sexually abused? ☐ Yes ☐ No

Explain if yes: _____

EDUCATION

Current school or last school attended: _____Grade Level:_____

Academic Functioning (grades): _____ Did the client ever receive special services in school? _____

Academic problems or special needs: _____

VOCATIONAL

Present job: _____ Employer: _____ Length of time at present job: _____

Work history: _____

LEGAL HISTORY

Are there any legal charges pending? ☐ Yes ☐ No Has the client ever been arrested? ☐ Yes ☐ No

Specify:

_____

Parent/Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____