



Client Name: _____

Child/Adolescent History From

Please provide the following information to help us understand your child's living situation:

Child's Last Name _____ First Name _____ M.I. _____				
Date of Birth _____ Age _____ Gender _____ Language _____				
Lives with _____ Relationship _____				
Primary Address _____ City _____ Zip Code _____				
Home Phone _____ Cell Phone _____ Work Phone _____				
Parent Name _____ Age _____				
Address ☐ same as above, or _____ City _____ Zip Code _____				
Home Phone _____ Cell Phone _____ Work Phone _____				
Marital Status (circle) Single Married Separated Divorced Widowed Cohabiting Other				
Parent has (circle all) Primary Custody Joint Custody Primary Placement Shared Placement				
Other members of household (list) _____				
Parent Name _____ Age _____				
Address ☐ same as above, or _____ City _____ Zip Code _____				
Home Phone _____ Cell Phone _____ Work Phone _____				
Marital Status (circle) Single Married Separated Divorced Widowed Cohabiting Other				
Parent has (circle all) Primary Custody Joint Custody Primary Placement Shared Placement				
Other members of household (list) _____				
Siblings Names	Sex	Age	Type (Bio, Step, Half, etc.)	Living Situation



Client Name: _____

Please provide the following information to help us understand your child's living situation:

Child's Name _____ Today's Date _____

Name of Parent/Guardian completing from: _____

What problem is your child having that concerns you?

When did the problem start?

Has the child ever received mental health treatment? If so where, when and by whom? _____

Has the child ever taken medication for emotional or behavioral problems? If so what, when and prescribed by whom? _____

What do you see as your child's strengths? _____

In the past month, what has been your child's biggest success or accomplishment? _____

Who does your child look to for help and support? _____

What are your family's strengths? _____

Who do you as a parent rely on for support and assistance? _____

Is your child receiving any other special help or therapies? _____



Client Name: _____

Medical History

Please answer the following questions regarding your pregnancy and delivery with this child:

Pregnancy

- ☐ Mother was healthy
- ☐ Mother had health problems: _____
- ☐ Mother smoked ☐ Used alcohol ☐ Used drugs
- ☐ Violence toward mother during pregnancy

Delivery

- ☐ Full-term ☐ Premature at _____ months ☐ Adopted at _____ of age
- ☐ List of any medical complications _____
- ☐ List any congenital problems _____
- ☐ Extended hospital stay for ☐ Infant and or/ ☐ Mother

Has your child had a history of medical problems? (Describe)

Have there been significant hospitalizations, operations, procedures or injuries? (Describe)

Are there current medical problems or concerns? (Describe)

Is the child currently taking medication? (List medication, dosage, reason for medication and prescribing physician)

Name of Child's Primary Care Physician/Pediatrician _____

Address: _____ **Phone:** _____

Has your child seen the Primary Care Physician/Pediatrician within the last past year? ☐ Yes ☐ No

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Below is a list of developmental concerns or problems. Check (X) to all that apply to your child.

	Description	At what age(s)?	Current Status (Describe)
	Slow to crawl		
	Slow to walk		
	Not like being touched or held		
	Difficulty with toilet training/bedwetting/soiling		
	Problems with sleep		
	Problems with sleeping		
	Problems with eating		
	Easily upset/hard to calm down		
	Not like being around people		
	Too active for child's age		
	Low energy		
	Physical disability		
	Learning Problems		
	Other:		

Check (X) and complete if your child is currently enrolled in:

- ☐ **School** Name _____ Address _____
Teacher _____ Grade _____ Phone Number _____
Does your child have an EAP? ☐ No ☐ Yes, for _____
- ☐ **Childcare** Name _____ Address _____
Contact Person _____ Phone Number _____
- ☐ **Other Program** Name _____ Address _____
Contact Person _____ Phone Number _____

Below is a list of experiences that some children have had to deal with. Check (X) to all that apply to your child.

	Teasing or bullying by another
	Conflict in family
	Separation from parent(s)
	Frequent moves in location
	Divorce
	Medical emergency or difficult procedure
	Death or loss of someone close
	Medical problem of parent
	Emotional problem of parent
	Drug/alcohol problem of parent
	Foster Care

	Physical abuse
	Sexual abuse
	Emotional or verbal abuse
	Witnessing violence at home
	Witnessing violence in the community
	A hurricane, flood, tornado or other bad storm
	Car crash or other serious accident
	Family member victim of crime
	Other event that extremely upset or bothered child (describe)

What would you like to see change for your child as a result for treatment? For yourself as a parent?
