Child /Adolescent Family History

(to be completed by parent/guardian)

Client's name: ____ Date Completed: ______________________

Parent/Guardian name: ____

School : _________________________ Grade: _______ Contact Teacher: ________________________

School Counselor: ________________________________

Family Concerns

What are your concerns for your child?

Please list any previous counselors:

Developmental History

Age client was: Toilet trained ______ Walked________ Talked________

Concerns during pregnancy	Yes	No		Parental Exposure to Drugs or Alcohol	Yes	No
Delivery complications	Yes	No		Developmental Milestone concerns	Yes	No
Normal Birth Weight	Yes	No		Temperament concerns	Yes	No
Postpartum depression	Yes	No		Bedwetting concerns	Yes	No
Gender Identity:				Any Other medical, social, or psychological problems	Yes	No
If yes, please explain and provide any previous services received.						

Medical History

Physician's Name______________________________ Phone Number _________________

Date of Last Comprehensive Medical Exam _________________

Serious illness that have required hospitalizations or surgery?

Please note any health conditions that has cause challenges in day to day living.
(e.g. Head Injury, hearing or vision problems, seizures, mobility, etc)

Please list any medications the client is currently taking

Name	Dose	Frequency	Reason

Behavioral / Trauma History

Suicidal Behavior	Yes	No		Sleep Problems	Yes	No
Acting Out Sexually	Yes	No		Weight Loss/Gain Problems	Yes	No
Aggressiveness/Delinquency	Yes	No		Past Psychiatric Hospitalizations	Yes	No
Drug/Alcohol Problems	Yes	No		Disturbing Thoughts	Yes	No
Runaway Behavior	Yes	No		Panic Attacks	Yes	No
Self Injurious Behavior (e.g. head hitting, cutting)	Yes	No		Hallucinations/Delusions	Yes	No
Any other Behavioral concerns:						
If Yes, Please explain:						

Witness to Violence	Yes	No		History of Physical Abuse	Yes	No
History of Peer Abuse	Yes	No		History of Sexual Abuse	Yes	No
Multiple Job Losses in Family	Yes	No		Multiple Moves/Loss of Housing	Yes	No
Extreme Financial Difficulties	Yes	No		Deaths or Losses (including pets)	Yes	No
If Yes, Please Explain.						

School History

Easily Motivated	Yes	No	Some-times	IEP / 504	Yes	No	Some-times
Gets Along with Teachers	Yes	No	Some-times	Behavior Plan	Yes	No	Some-times
Peer Relationships, Conflicts or Concerns.	Yes	No	Some-times	Attentional Difficulties	Yes	No	Some-times
Academic Challenges	Yes	No	Some-times				
If Yes/Sometimes, Explain:							

Family History

Biological Mother				Biological Father		
Child Abuse or Neglect History	Yes	No		Child Abuse or Neglect History	Yes	No
Sexual Abuse History	Yes	No		Sexual Abuse History	Yes	No
Alcohol / Drug Abuse History	Yes	No		Alcohol / Drug Abuse History	Yes	No
Mental Health History	Yes	No		Mental Health History	Yes	No
Suicide History	Yes	No		Suicide History	Yes	No
Learning Disabilities	Yes	No		Learning Disabilities	Yes	No
Divorce / Separations	Yes	No		Divorce / Separations	Yes	No
Any other information you would like us to know? (e.g. medical, social, legal)				Any other information you would like us to know? (e.g. medical, social, legal)		
If yes to any of the above, please explain:				If yes to any of the above, please explain:		

Please list or diagram client’s family systems e.g. caregivers, siblings, relatives, etc.

Please list family support systems e.g. church, clubs, extended families, friends, etc.

Name some of the client’s strengths:

Name some of your family’s strengths:

Culture / Ethnic / Spiritual influences:

Goals for the client:

What else do you feel would be important from me to know.