

### 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	Other			
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?