Associates In Mental Health Administrative Office *(360) 715-2488 Phone*
1116 Key St Ste 204 Bellingham, WA 98225 *(360) 671-1842 Fax*

Child/Adolescent Family History

(to be completed by parent/guardian)

Client Name: ____ **Date**: ______/______/___________

Parent/Guardian Name: ____

School: ____ **Grade**: _______
Contact Teacher: _____________________________ **School Counselor**: _____________________________

Family Concerns

What are your concerns for your child?

Please list any previous counselors/therapists:

Developmental History

Age client was: toilet trained: __________________ walked: __________________ talked: ___________________

Gender Identity:	N/A	N/A	Parental Exposure to Drugs/Alcohol	Yes	No
Concerns During Pregnancy	Yes	No	Developmental Milestone Concerns	Yes	No
Delivery Complications	Yes	No	Temperament Concerns	Yes	No
Normal Birth Weight	Yes	No	Bedwetting Concerns	Yes	No
Postpartum Depression (or other DSM DX)	Yes	No	Other Medical/Social/Psychological Issues	Yes	No

If Yes, please explain and describe any previous services received: _______________________________________
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Medical History

Primary Care Physician: ____ Phone: _______________________
Date of last comprehensive medical exam: ______/______/____________

Serious illnesses that have required hospitalizations or surgery?

Please describe any health conditions having caused challenges in day-to-day living (i.e. brain injury, hearing or vision problems, mobility, etc.):

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Please list any medications client is currently taking:

Name	Dosage	Frequency	Reason

Behavioral/Trauma History

Suicidal Behavior	Yes	No	Sleep Issues	Yes	No
Self-injurious Behavior (I.e. head hitting, cutting)	Yes	No	Weight Loss/Gain Issues	Yes	No
Aggressiveness/Delinquency	Yes	No	Disturbing Thoughts	Yes	No
Drug/Alcohol Issues	Yes	No	Panic/Anxiety Attacks	Yes	No
Runaway Behavior	Yes	No	Hallucinations/Delusions	Yes	No
Acting Out Sexually	Yes	No	Past Psychiatric Hospitalization(s)	Yes	No
Other Behavioral Concerns	Yes	No	Other Emotional Concerns	Yes	No

If Yes, please explain: ______________________________

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Witness to Violence	Yes	No	Deaths/Losses (Including Pets)	Yes	No
History of Physical Abuse	Yes	No	Multiple Moves/Loss of Housing	Yes	No
History of Sexual Abuse	Yes	No	Extreme Financial Difficulty	Yes	No
History of Peer Abuse	Yes	No	Multiple Job Losses in Family	Yes	No

If Yes, please explain: ______________________________

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School History

Easily Motivated	Yes	No	Sometimes	IEP/504	Yes	No	Sometimes
Gets Along with Teachers	Yes	No	Sometimes	Behavior Plan	Yes	No	Sometimes
Peer Conflicts/Concerns	Yes	No	Sometimes	Attentional Difficulties	Yes	No	Sometimes
Academic Challenges	Yes	No	Sometimes	Other	Yes	No	Sometimes

If Yes/Sometimes, please explain: ______________________________

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Family History

Biological Mother

Abuse/Neglect History	Yes	No	Suicidality History	Yes	No
Sexual Abuse History	Yes	No	Learning Disabilities	Yes	No
Alcohol/Drug Abuse History	Yes	No	Divorces/Separations	Yes	No
Mental Health History	Yes	No	Other (Medical/Social/Legal)	Yes	No

If Yes, please explain: ______________________________

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Biological Father

Abuse/Neglect History	Yes	No	Suicidality History	Yes	No
Sexual Abuse History	Yes	No	Learning Disabilities	Yes	No
Alcohol/Drug Abuse History	Yes	No	Divorces/Separations	Yes	No
Mental Health History	Yes	No	Other (Medical/Social/Legal)	Yes	No

If Yes, please explain: ____

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Please list or diagram client's family system (i.e. caregivers, siblings, relatives, etc.):

Please list family support systems (i.e. extended family, friends, church, clubs, etc.):

Name some of client's strengths:

Name some of your family's strengths:

Culture/Ethnic/Spiritual Influences:

Goals for Client:

What else do you feel would be important for me to know?