*Associates In Mental Health Administrative Office* *(360) 715-2488 Phone*
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# *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: _____
_____
_____
_____
_____

## 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.):

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: _____
_____
_____
_____
_____

| | | | | | |
|---|---|---|---|---|---|
| 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: _____
_____
_____
_____
_____

**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: _____
_____
_____
_____
_____

**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: _____
_____
_____
_____
_____

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: _____
_____
_____
_____
_____

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?