Client History Form

General Information:

Name of client: _____

Date of Birth: _____Age: _____ Gender: _____

Family Information:

Father's Name: _____

Mother's Name: _____

Parents are: ___ Married ___ Separated ___ Divorced ___ Never married
Names/ages of family members living inside the home:

Names/ages of family members living outside of the home:

Family Health/Mental Health History:

Describe your relationship with the child:

Describe your child's relationship with his/her siblings:

What type of discipline do you use in the home with your child?

Child's Developmental History:

How was your pregnancy with your child (i.e. easy, bedrest)? _____

_____

Birth of child: (i.e. full term, premature, complications)_____

Did mother abuse alcohol or drugs during pregnancy? _____

Describe child's infancy years (i.e. fussy, calm): _____

Were there any significant developmental delays during infancy? If so, please explain: _____

Were there any significant developmental delays during toddlerhood? If so, please explain: _____

_____

Does your child have any developmental delays at their current age? If so, please explain: _____

Child's Medical History

Primary Care Physician: _____ Date of last exam: _____

Name of Primary Care Physician Clinic: _____
Would you like therapist to have contact with your child's PCP?: Yes ____ No____ (*If answer is YES, a release will need to be completed and therapist will send a brief note stating the child has started working with therapist on said date).*

Does your child have any medical conditions? _____

_____

Does your child meet with a Psychiatrist or ARNP, separate from their PCP? Yes ___ No___

If yes, please indicate name and clinic of Psychiatrist/ARNP: _____

Please list all medications your child is currently taking:

Name of Medication	**Dosage**

Has your child received therapy before? Yes ___ No ___ If yes, please briefly explain the issues that were worked on:

Child's Education History:

Current School: _____

Type of school: Public ___ Private ___ Homeschool ___ Other (specify) _____

Current Teacher:_____ Last grade completed: _____

Does your child meet with another teacher outside of the regular classroom? If yes, please answer below:

Program	Yes/No	Teacher
Special Education		
Gifted Program		
School Counselor		
Reading Program		
Behavioral Intervention		
Other:		

What does your child enjoy about school?_____

What does your child dislike about school? _____

Does your child have an: IEP ___ 504 Plan ___?
Has your child undergone psychological testing? YES ___ NO ___ If YES, are you willing to share the results:

Reasons for seeking therapy for your child (please thoroughly explain all that apply):

Behavior:	
Attention Difficulties: *Inattention and hyperactivity, inability to pay attention and complete schoolwork, chores, daily tasks.*	
Anger: *Anger outbursts, defiance, refusal to comply with rules.*	
Anxiety: *Difficulty separating from caregiver, panic, specific phobias, fear of doing things that are typical for his/her age.*	
Conduct Issues*:* *Lies, steals, runs away, non-compliance with rules/laws*	
Depression: *Frequent sadness, undesired to do activities they would normally enjoy, isolates self, appetite loss, sleeps often.*	
Trauma: *Physical and/or sexual abuse, witness domestic violence, exposure to an event*	

What stressors are going on with your child/family at this time?_____

_____

What goals do you have for your child in therapy? _____

_____

Please add any additional information you would like for me to know about your child/family:

_____

Thank you for taking the time to help me better understand your child and their therapy needs!