Identifying Information:		
Client Name:	Date:	
Date of Birth:	Male	Female
The information in this form is very important to you also very important to the success of your treatment that as possible. Please answer the questions as honestly a information. If a question does not apply to you or you all other information you provde, is confidential.	hat your counselor unde s you can, and feel free	erstands as much about you to explain or add any other
Presenting Problems:		
1. Please describe the primary reason for seeking courdisorder, depression, anxiety, etc.	nseling, i.e. substance a	buse, self-harm, eating
2. Do you think this is a very important problem? If y	es please explain:	
3. How long has this been a problem?		
4. Is this a recurrent problem? YesNo		
5. Has this affected you and your family? If so please	explain how.	
6. Does your child believe he/she has a problem? Y	Yes No	
7. Does anyone in your child's immediate or extended	d family have a similar	problem? Please explain.

Family/Cultural History:

1.What is your child's ethnicity?
2. Do you, your child, or your family identify with a particular cultural or ethnic group? Please explain.
3. Has this played an important role in any current problems with your child? Please explain.
4. In whose custody has your child spent most of his/her childhood?
5. In what city or area has your child been raised?
6. What is the Father's name, age, and job? If deceased, how and when?
7. What is the Mother's name, age, and job? If deceased, how and when?
8. If applicable, what is the Step-Father's name, age, and job? If deceased, how and when?
9. If applicable, what is the Step-Mother's name, age, and job? If deceased, how and when?
10. Is you child adopted? Yes No 11. If so, does he/she know about his/her birth parents? Yes No.

12. With whom does your child live?
13.How is he/she disciplined?
14.By whom is he/she disciplined?
15. If any, what are the names, ages, and genders of any siblings including step and half siblings? Do they live in the same place as him/her?
16. Please write any significant family history (include marriages, separations, substance/pyshical abuse, violence, death, disruptions, suicide/homicide).
17. How is your family supported? Parent/Guardian Employment Public Assistance Other, please explain 18. Are there any Family legal issues? (sexual abuse, custody, foster care, etc.)
19. Has your child had legal circumstances (i.e. criminal, wardship, custody, foster care)? Please explain
20. Who in your family is your child closest to? Please explain.

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21. Have any deaths or losses affected your child? Please explain.
Developmental History: 1. Pregnancy and birth information (length of pregnancy, birth length and weight, etc.)
2. Milestones (walk, talk, toilet trained, etc):
3. Pre-natal exposure to Alcohol, Tobacco and Other Drugs (ATODs)? Yes No If yes, please describe:
4. Please list immunizations and date received:
5. Major illness (type/age of onset):
6. Allergies (type/age of onset):
7. Current medications, start date of meds, and name of prescribing doctor:
8. Has he/she ever had any kind of head injury? If so, when and how?
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9. Has he/she ever lost consciousness as the result of	an injury?	If so, when and how?
0. Has he/she ever had any of the following? If so,	_	•
☐ frequent nightmares; age		alcohol use; age
□ sleep walking; age		gambling; age
□ thumb sucking; age		criminal acts/non-violent; age
□ stuttering; age		criminal acts/violent; age
□ nail biting; age		truancy from school; age
□ excessive fear; age		running away from home; age
□ bed wetting; age		gang membership or participation; ag
□ soiling; age		
□ difficulty with language/speech; age		involvement with weapons; age
difficulty with hearing; age		suicide attempts; age
☐ difficulty with vision; age		eating disorder; age
□ trouble with police; age		mood difficulties; age
□ trouble with authorities; age		mental illness; age
□ temper problems; age		fire starting; age
sexual activity; age		treatment/mental health; age
□ pregnancy (self or girlfriend); age		treatment/substance abuse; age
		hurt animals; age
□ cigarette use; age		
1. Has he/she had any learning difficulties? If so, pl	lease explai	n.
2. How many schools has he/she attended?		
3. Reasons for change of school?		
4. Does your family belong to a spiritual organizati	on? If so, w	hich?
·		
5. Does your child attend/participate? Yes	No	

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16. Does he/she like participating? Please explain.						
17. Wi	ll this affect treatment? If so, how	?				
18. Is l	ne/she sexually active? Yes		No	Unsure		
19. Ha	s he/she ever been sexually abused	1? If	so, please explain, in	ncluding who	abus	sed him/her.
20. Do	es he/she use birth control? If yes,	wha	nt type?			
21. Do	es he/she practice safe sex techniq	ues,	if applicable?			
22. Ple	ease indicate if your child has ever			g?		
	depression		panic attacks			feeling helpless
	fears		sleep problems			feeling hopeless
	paranoid or		guilt			feeling inadequate
	suspicious thoughts		fighting			setting fires
	seeing or hearing		mood swings			hostile feelings or
	things		memory problems			actions
	low self-esteem		irrational beliefs			hurting animals
	nervousness		appetite disturbanc	es		strange, unexplained
	hurting self		frequent headaches	S		thoughts, sensations,
	anxiety		frequent stomach			or feelings
	suicidal thoughts or		aches			poor concentration
	attempts		frequent gastric up	set		

23. Does he/she watch TV or play videos? If so, how many hours per day are spent at this activity?
24. Which types of shows or movies does he/she prefer?
25. How much leisure time do you spend with your child?
26. Are you satisfied with your child's use of leisure (non-school) time? Please explain.
27. Does he/she eat a well balanced diet? What types of food do they eat daily?
28. Do you think your child has an eating problem? If so, please explain.
29. What types of vitamins/food supplements does he/she take and how often are they taken?
30. Does he/she avoid any of the major food groups? If so, which?
31. Would you like a referral to a dietitian for your child?

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32. What do you hope your child will receive from tro	eatment?	
33. What will happen if your child's problems are no	resolved through this treatment?	
34. Please list any past treatment your child has receiproviding treatment.	ved, including the dates, purpose, and	d person
35. Is there anything else you would like to tell us in situation?	order to help us understand your chil	d and his/her
Signature:		
Client/Parent or Guardian Signature	Date	
Therapist Signature	 Date	