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CLIENT HISTORY QUESTIONNAIRE

Client's name: _____ Date: _____

Date of birth: _____ Age: _____ Grade in school: _____ Form completed by: _____

Address: _____ City:_____ State: : _____ Zip: _____

Best number(s) to reach you: _____

Email(s):_____

Primary reason(s) for seeking services:

Anger management	Coping problems	Moodiness/Irritability	Depression	Anxiety
Academic problems	Fears/Phobias	Parenting concerns	Autistic Spectrum	Social problems
Sleeping problems	Compulsive behaviors	Family problems	Hyperactivity/Impulsivity	

Other mental health concerns (specify): _____

Family Background

With whom does the child live at this time?

_____

Are parents divorced or separated? No Yes If yes, who has legal custody:_____

If separated or divorced and you share custody, list when the child is with you and the other parent:

_____

Name(s) of step-parent(s)

_____

Client's Parent/Guardian

Name_____ Age: _____ Education and employment: _____

Client's Parent/Guardian

Name_____ Age: _____ Education and employment: _____

Is there anything notable, unusual or stressful about the child's relationship with either parent/guardian?

No Yes, please explain:

_____

Client's Siblings and Others Who Live in the Household(s)

Name of Sibling/Other Age Name of Sibling/Other Age

_____ _____

_____ _____

Childhood/Adolescent Developmental History

Pregnancy/Birth

Any prenatal medical/emotional difficulties for the mother (e.g. surgery, hypertension, medication) No Yes

If yes, please describe: _____

Length of pregnancy:_____ Birth weight _____

While pregnant did the mother smoke? No Yes If Yes, what amount: _____

Did the mother use drugs or alcohol? No Yes If Yes, what amount: _____

Describe any birth problems or complications.

_____

Describe any complications for the mother or the baby after the birth.

_____

Developmental History

Please indicate if your child met their milestones in an average, early, or delayed timeframe.

Sat alone: *Average Early Delayed* Crawled: *Average Early Delayed* Walked: *Average Early Delayed*

Fed self: *Average Early Delayed* Dressed Self: *Average Early Delayed* Spoke words: *Average Early Delayed*

Spoke Sentences: *Average Early Delayed* Completed Potty Training: *Average Early Delayed*

Education

Current school: _____ Grade: ____ Grades/Academic Performance: _____

IEP/504 Plan? No Yes, describe: _____

In gifted program? No Yes, describe:_____

Favorite subjects:_____ Least favorite subjects: _____

Have there been any recent changes in the child's grades? No Yes, describe: _____

Are there additional notes about the child's education that you would like to include? _____

_____

Child's Peer Relationships

___ Makes friends easily ___ Follower ___ Leader ___ Difficulty making friends ___ Long-term friendships

Other, describe: _____

Has the child experienced death (friends, family, pets, other): No Yes, please describe: _____

_____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, reading, sports, church, school activities, scouts, etc.)

Activity/How often?	Activity/How often?
_____	_____
_____	_____

Medical/Physical Health

List any current health concerns: _____

List any recent health or physical changes: _____

Recent changes in the child's appetite? None Increased Decreased Recent significant weight change: Yes No

List any hospitalizations, significant accidents, surgeries, head injuries, etc: _____

_____

Primary Doctor/Practice Name: _____

All prescribed/herbal/over the counter medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Psychological/Psychiatric Treatment History

	No	Yes	When	Where/With Whom Purpose
Therapy	_____	_____	_____	_____
Suicide attempts	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____
Psychiatric Hospitalizations	_____	_____	_____	_____
Psychological testing	_____	_____	_____	_____

Current Behavioral/Emotional Symptoms

Please check any of the following that are typical for your child:

Frustrated easily	Sad/Depressed	Alcohol/Drug use	Moody	Steals Withdrawn
Aggressive	Separation anxiety	Impulsive	Shy, timid	Talks back
Hallucinations	Worries excessively	Anxious/Fearful	Irritable	Nightmares
Panic attacks	Sexual acting out	Speech Problems	Sick Often	Sleeping Problems
Hopelessness	Phobias	Bullies, threatens	Stomachaches	Angry
Short attention span	Eating disorder	Destructive	Bed wetting	Suicidal statements
Suicide attempts	Lies frequently	Low self-esteem	Tics	Defiant/Oppositional

Other, please describe: _____

Have there been any other significant changes or events in your child's life? (new home, moving, fire, new school, etc.): No Yes, describe: _____

What are your goals for the child's therapy? _____

What family involvement would you like to see in the therapy? _____

Do you believe the child is suicidal at this time? No Yes, please explain_____

_____

Please use this page to provide any additional information
that you believe would assist me in understanding your child.