Associates in Mental Health
Administrative Office: (360) 715-2488

# CHILD/ADOLESCENT FAMILY HISTORY FORM

(to be completed by parent/guardian)

Date: _____ Form completed by: ☐ Mother ☐ Father ☐ Stepparent ☐ Guardian

**Client Name:** _____ Personal Pronouns: _____

Parent/Guardian Name: _____

School: _____ Grade: _____

Contact Teacher: _____ School Counselor: _____

**Family Concerns:**

## Medical History

Primary Care Physician: _____ Doctor's Office: _____ Phone Number: _____

Date of client's last physical exam: _____ Examined by: _____

List serious illnesses that have required hospitalizations or surgery:

1. _____
2. _____
3. _____

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

List all medications client is currently taking; including non-prescription drugs and health supplements:

| Drug Name | Dosage | # Per Day | Drug Name | Dosage | # Per Day |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## Developmental History

Age client: was toilet trained: _____ walked: _____ talked: _____

Does gender identity match assigned at birth? ☐ Yes ☐ No If not, what age did they start transition? _____

| Any history of the following: | Yes | No | Any history of the following: | Yes | No |
|---|---|---|---|---|---|
| Parental exposure to drugs/alcohol during pregnancy? | | | Temperament concerns? | | |
| Concerns during pregnancy? | | | Developmental milestone concerns? | | |
| Delivery complications? | | | Bedwetting concerns? | | |
| Normal birth weight? | | | Other medical/ social/ psychological issues? | | |
| Parent- postpartum depression? | | | Other medical/ social/ psychological issues? | | |

For any "yes," please explain and describe any services received: _____

## Behavioral/Trauma History

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Suicidal behavior | ☐ | Sleep issues | ☐ | Witness to violence |
| ☐ | Self-injurious behavior (i.e. head hitting, cutting) | ☐ | Weight gain/loss issues | ☐ | History of physical abuse |
| ☐ | Aggression/ Delinquency | ☐ | Disturbing thoughts | ☐ | History of sexual abuse |
| ☐ | Drug/ Alcohol issues | ☐ | Panic/ anxiety attacks | ☐ | History of peer abuse |
| ☐ | Runaway behavior | ☐ | Hallucinations/ Delusions | ☐ | Death/ Losses (including pets) |
| ☐ | Acting out sexually | ☐ | Past psychiatric hospitalization(s) | ☐ | Multiple moves/ Loss of housing |
| ☐ | Other behavioral concerns | ☐ | Other emotional concerns | ☐ | Multiple job losses in family |

Please explain any checks:

Has the client had any previous mental health counseling? ☐ Yes ☐ No If yes, describe below:

| Location/Therapist | Dates | Reason |
|---|---|---|
| | | |
| | | |
| | | |

## School History

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | Struggles with motivation | ☐ | Has IEP/504 | ☐ | History of fighting | ☐ | Has school friends |
| ☐ | Easily motivated | ☐ | Has behavior plan | ☐ | Peer conflict/ concerns | ☐ | Attention/focus concerns |
| ☐ | Does not along with teachers | ☐ | Academic challenges | ☐ | Attendance concerns | ☐ | Enjoys school |
| ☐ | Gets along with teachers | ☐ | Excels academically | ☐ | Engages in afterschool activities | ☐ | Other |

Describe any checks:

## Family History

Biological Mother

| | | | | | |
|---|---|---|---|---|---|
| ☐ | History of abuse/ neglect | ☐ | History of suicidal ideation | ☐ | History of mental health concerns |
| ☐ | History of sexual abuse | ☐ | History of attempted suicide | ☐ | Divorces/ Separations |
| ☐ | History of substance abuse | ☐ | Learning disabilities | ☐ | Other (medical/ social/ legal) |

Please explain any checks:

Biological Father

| | | | | | |
|---|---|---|---|---|---|
| ☐ | History of abuse/ neglect | ☐ | History of suicidal ideation | ☐ | History of mental health concerns |
| ☐ | History of sexual abuse | ☐ | History of attempted suicide | ☐ | Divorces/ Separations |
| ☐ | History of substance abuse | ☐ | Learning disabilities | ☐ | Other (medical/ social/ legal) |

Please explain any checks:

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

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

Name some of the client's strengths:

Name some of your family's strengths:

Culture/ Ethnic/ Spiritual/ Religious influences:

Goals for client:

What else is important for the therapist to know?