Initial Psych-Social Information

Today's Date:_____

Client's Name_____ Sex: M___ F___

****

Please briefly describe the reasons you are seeking counseling or the reasons you are bringing your child in today, and what outcome you are hoping for:_____

_____

_____

_____

_____

_____

_____

_____.

****

Family

Please check the one marital or living situation listed below that describes you:

1)____ Married and living with spouse

2)____ Separated/Divorced from spouse. Who is custodial parent?_____

Have you been receiving/paying support payments? Yes___No___

3)____ Single and living with child's father/mother

4)____ Single and living with your parents

5)____ Single and living with another male or female adult – who shares household responsibilities

6)____ Single and living with another male or female adult – who does not share household responsibilities.

7)____ Other (please explain):_____

Child Client's Sibling Information

Please list the names, ages, and grade in school, (if still in school) for siblings, living or not living in the home. Also list the relationship, i.e. brother, sister, stepbrother, foster...(Use back of this page if more room is needed)

Name	Age	Grade	Relationship
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____

1. Adult Client or Child Client's **Parent's** (Mom & Dad) family of origin experience (ie: Siblings, family relationships, Childhood Trauma, Grief & Loss, parent's parents style of parenting etc) (Often children with difficulties are very good at pushing their parents "buttons." It is helpful for Therapists to be aware of parent's experience in their family of origin. Please us the back of this page for your history. **IF YOUR CHILD HAS ATTACHMENT DIFFICULTIES, SKIP THIS QUESTION. YOU WILL RECEIVE ANOTHER QUESTIONAIRRE THAT ADDRESSES THIS.**

2. Child Client's Childhood family experience (ie: Placement History, Trauma, Abuse, Grief & loss, etc) use back of this page if necessary _____
_____
_____

3. Issues of conflict within family _____
_____
_____

4. Strength of Support (ie: extended family, community, friends, etc) _____
_____
_____

Child's History and Development

1. Please check: Is this your Biological child?_____Adopted?_____ Foster? _____ Stepchild? If other than your Biological child, at what age did he/she come into your home?_____.

2. Did Birth Mother have any illnesses or complications during pregnancy with this child? Yes___No___. If yes, please specify:_____
_____.

3. Did Birth Mother take any medications, drugs, alcohol, or tabacco during pregnancy? Yes___No___. If yes, please specify:_____
_____

4. Did Birth Father (father in the home during pregnancy) take any drugs, alcohol, or tabacco during pregnancy? Yes___No___. If yes, please specify:_____
_____.

5. Was this pregnancy planned?___Unplanned?___Full-term?____Premature?____ Birthweight:_____ APGAR:_____

6. Was there anything unusual about the delivery of this child? Yes___No___ If yes, please describe what happened:_____
_____.

7. At what age did this child crawl?_____walk?_____

8. If this child is having, or has had problems in any of the following areas of development, please briefly describe.

a. Small muscle development (i.e. finger/hand coordination):_____
_____.

b. Large muscle development (i.e. walking, running, jumping):_____
_____.

c. Speech and Language:_____
_____.

d. At what age was your child potty trained?_____ Are their current problems?_____
_____
_____.

e. Thinking and Problem Solving (i.e. cognitive skills): _____
_____.

f. Getting along with other children, making friends:_____
_____.

g. Self-care (e.g., feeding, dressing, grooming):_____
_____.

h. Strength/Weaknesses: _____
_____

i. Other:_____
_____

Child's School/Day Care Information

Is this child in school? Yes__No__ If yes what grade?_____
Has He/She ever repeated a grade? Yes__No__ If yes, what grade?_____

Name of School(s):_____
Phone:_____
Teacher(s):_____
School Counselor:_____

Is this child in Day Care? Yes__No__
Name of Day Care:_____Phone:_____
Primary Contact:_____

Substance Abuse

(Child or Adult Client's use or Child's Parents Use)

Please note family use history, personal use history, current use pattern, substance(s) used, frequency, amount and consequences of use, and treatment history/outcome. (Skip this section if N/A)

_____
_____
_____
_____
_____
_____
_____

Socio-Economic

(As pertains to Parent or Adult Client)

1. Educational History: _____
   _____
   _____

2. Employment Status & History: _____
   _____
   _____

3. Financial Status/Stresses: _____
   _____

4. Social Support Network: _____
   _____

5. Military and Legal History: _____
   _____

6. Client's Cultural/Spiritual/Recreational (sports, music, etc) Activities: _____
   _____

Psychiatric

Has your child had previous counseling? Yes___No___ If yes, please list names of previous counselors and the approximate dates of counseling or other related Mental Health Services: (ie: PSR, partial care, inpatient, residential, etc)

Name of counselor or other Counseling Facility	Sequential Dates of Counseling
_____	_____
_____	_____
_____	_____
_____	_____

1. List all previous and current mental health diagnoses and who determined the diagnoses.

_____
_____
_____

2. List all mental health medications taken previously and currently (include prescribing physician, dosage and length of time on each medication and reason for stopping (use the back of this form if you need more space)_____

_____
_____
_____
_____

3. Describe any current or past concerns you have about your child's emotional, intellectual or academic functioning. _____

_____
_____

4. Are there other people or circumstances that contribute to the concerns that you have about your child (e.g., other family members, marital conflicts, changes in the home,etc.)?

_____
_____
_____
_____

5. Has your child ever been physically, emotionally or sexually abused? If yes, please explain.

_____

6. Has your child ever experienced a period of time, before age four, without his/her primary caregiver?_____

_____
_____

Medical

1. Please list all childhood diseases your child has had (i.e. measles, chicken pox, mumps, etc.)

_____

_____

2. Please list any allergies and allergy medications your child currently takes) your child has:

_____

_____

3. Name of Child or Adult Client's Primary Care Provider._____
   a. Providers Address: _____
   b. Providers Phone #: _____

Biological Family History

Please check all that apply in client's Biological family, past or present:

	Mother	Mother's side of family	Father	Father's side of family
Asthma				
Seizures (Epilepsy)				
School or Learning Problems				
Mental/Emotional Disorders, (i.e. Depression PTSD, Anxiety,ADHD, etc.)				
Allergies				
Vision or Hearing Disorder				
Diabetes				
Adoption/Foster Care				
Birth Defects				
Mental Retardation				
Alcohol or Drug Abuse				
Physical, Emotional, and /or Sexual Abuse				
Severe Marital/Family conflicts				
Other conditions or problems, please specify				

_____ _____

(Name of person completing form) (Relationship)