Gloria Sánchez-Pérez, LMFT

Child/Adolescent History

Client Name: _____ Date: _____

Gender: _____ F _____ M Date of Birth: _____ Age: _____

Form completed by (if someone other than client): _____

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

Phone (home): _____ (cell): _____

Parent's Name:_____ Best contact Number: _____

Address (if different): _____

Parent's Name:_____ Best contact Number: _____

Address (if different):_____

Parent's Status: _____Married _____Single (never married) _____Divorced
_____Unmarried, living together

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services:
_____ Anger management _____ Anxiety _____Coping _____Depression
_____ Eating disorder _____Fear/phobias _____Hyperactivity/attention problems
_____Oppositional behavior _____ Sexual concerns _____Sleeping problems _____Alcohol/drugs
_____ Other mental health concerns (specify): _____
_____

Family Information

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
Mother	_____	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____	_____
Siblings	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____

Significant others (e.g., grandparents, step-relatives, half-relatives). Please specify relationship.

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Development

Are you being raised by person other than parents? _____ Yes _____ No If yes, please explain:

_____

Are there special, unusual, or traumatic circumstances that affected your development?

_____ Yes _____ No

If Yes, please describe: _____

Has there been history of child abuse? _____ Yes _____ No

If Yes, which type(s)? _____Sexual _____Physical _____Verbal

If Yes, the abuse was as a: _____Victim _____Perpetrator

Other childhood issues: _____Neglect _____Inadequate nutrition _____Other (please specify):

_____

Comments re: childhood development: _____

Social Relationships

Check how you generally get along with other people: (check all that apply)

_____Affectionate _____Aggressive _____Avoidant _____Fight/argue often _____Follower
_____Friendly _____Leader _____Outgoing _____Shy/withdrawn _____Submissive
_____Other (specify): _____

Any current or history of being a sexual perpetrator? _____Yes _____No

If Yes, describe: _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? _____Yes _____No

If Yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious

How important to you are spiritual matters? _____Not _____Little _____Moderate _____Much

Are you affiliated with a spiritual or religious group? _____Yes _____No

If Yes, describe: _____

Were you raised within a spiritual or religious group? _____Yes _____No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? _____Yes _____No

If Yes, describe: _____

Legal

Current Status

Have you ever been arrested? _____Yes _____No

If Yes, please describe and indicate date(s) and charges: _____

_____

Are you presently on probation or parole? _____Yes _____No

If Yes, please describe: _____

Are you hoping to use the therapeutic process in your court proceedings? _____Yes _____No

Education

Fill in all that apply: Years of education:_____ Currently enrolled in school? _____Yes _____No

Current grade: _____ Name of School:_____

School related problems:_____

Special circumstances (e.g., learning disabilities, gifted): _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

List any current health concerns: _____

List any recent health or physical changes: _____

Current prescribed medications	Dose	Dates	Purpose	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications/drugs? _____Yes _____No

If Yes, which ones: _____

	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctor's visit	_____	_____	_____

Family history of medical problems: _____

Please check if there have been recent changes in the following:

____Sleep patterns ____Eating patterns ____Behavior ____Energy level

____Physical activity level ____General disposition ____Weight ____Nervousness/tension

Describe changes in areas in which you checked above: _____

_____

Counseling/Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric Treatment	____	____	_____	_____	_____
Suicidal thoughts/ Attempts	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____

Do you feel suicidal at this time? _____Yes _____No

If Yes, explain: _____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

____ Aggression	____ Elevated mood	____ Phobias/fears
____ Alcohol dependence	____ Fatigue	____ Recurring thoughts
____ Anger	____ Gambling	____ Sexual addiction
____ Antisocial behavior	____ Hallucinations	____ Sexual difficulties
____ Anxiety	____ Heart palpitations	____ Sick often
____ Avoiding people	____ High blood pressure	____ Sleeping problems
____ Chest pain	____ Hopelessness	____ Speech problems
____ Cyber addiction	____ Impulsivity	____ Suicidal thoughts
____ Depression	____ Irritability	____ Thoughts disorganized
____ Disorientation	____ Judgment errors	____ Trembling
____ Distractibility	____ Loneliness	____ Withdrawing
____ Dizziness	____ Memory impairment	____ Worrying
____ Drug dependence	____ Mood shifts	____ Other (specify):
____ Eating disorder	____ Panic attacks	_____

What do you hope to achieve through therapy?

_____

_____

Therapist's signature/credentials: Date:

_____ _____