CYPRESS
COUNSELING CENTER, P.C.

CHILD CLIENT HISTORY

Name: _____ DOB: _____ Age: _____

Race/Ethnicity: _____ Sex: _____ Gender identity: _____ Sexual orientation: _____

Address: _____ City/State/Zip: _____

School: _____ Grade: _____

Pediatrician's name: _____

Psychiatrist's name: _____

Father's full name: _____ Occupation: _____

Mother's full name: _____ Occupation: _____

Names and ages of siblings: _____

_____

Other family members (i.e. step-parents) and/or persons living in the home (please include relationship to child and age): _____

_____

Language(s) spoken at home:_____

Please describe the events that led to the decision to seek therapy at this time. _____

_____

_____

In your opinion, what has caused these problems? _____

_____

When did these concerns first begin? _____

Physical and Mental Health

Please list previous psychiatric hospitalizations (hospital, dates, & reason for hospitalization):

_____

_____

Has your child ever been in therapy before? If so, please describe (i.e. therapist name, agency, dates, & type of therapy):

_____

_____

Please describe any psychiatric problems or mental health concerns in your child's family and extended family (please include diagnoses, medications, suicidal ideation/attempts, hospitalizations):

_____

_____

Please describe your child's history of traumatic experiences (Including, but not limited to, verbal/physical/emotional/sexual abuse, neglect, divorce, loss of a loved one, witnessing violence) :

_____

_____

Please describe illnesses, hospitalizations, surgeries, or other significant health issues that your child has had and when they occurred:

_____

_____

List any medications your child is taking (Name, dosae, and frequency; Medical and psychotropic).

_____

_____

List your child's history of psychotropic medications (include adverse reactions or ineffective medications).

_____

Any issues with significant weight loss/gain? If yes, please describe:

_____

Challenges with eating (i.e. not eating, binging, overeating, picky eater, anorexia, bulimia, etc.)?

_____

Challenges with sleep (i.e. difficulty falling asleep or staying asleep, nightmares, night terrors, bed wetting, etc.)?

_____

_____

Birth History and Developmental History

If your child was adopted, please indicate age at adoption and country of adoption. _____

_____ Is your child aware of adoption? YES NO

If your child was adopted, please include all developmental information that you have knowledge of.

Planned Pregnancy (Y/N)? _____ Length of pregnancy: _____

Duration of labor _____

Type of Delivery: normal _____ breech _____ Cesarean _____

Birth weight: _____ lbs. _____ oz. _____
Did the baby have any of the following (please answer Yes or No):
Jaundice _____ feeding difficulty _____ breathing difficulty _____ surgery _____

Did mother smoke during pregnancy (Y/N)? _____ Amount: _____

Did mother use alcohol or other drugs (Y/N)? _____ Type & amount: _____

During pregnancy, did mother have any medical or emotional difficulties (e.g. hypertension, surgery, medication, depression)? If yes, please describe:

_____

_____

Did mother experience any postpartum depression (Y/N)?: _____

Describe any particular eating or feeding problems as an infant/toddler (e.g. overeating, undereating):

_____

Describe your child as an infant (happy, nervous, overactive, underactive, playful, etc.): _____

_____

Describe any changes/differences as a toddler: _____

Who are child's caregivers other than parents (caretaker, arrangements, child's age):

_____

_____

Describe any past/current problems with wetting or soiling: _____

_____

Please indicate the age at which child completed the following:

Toilet trained _____ Dry during day _____ Dry during night _____

Took steps _____ Spoke words _____ Sentences _____

Toilet trained _____ Fed self _____ Dressed self _____

Tied shoe laces _____ Rode 2-wheel bike _____

Has your child hit puberty yet? If so, at what age did body changes and/or menstruation first occur?

_____

Does your child have any sensory sensitivities (i.e. sensitivity to loud noise, texture of clothing, food, etc.). If yes, please explain:

_____

Family Environment

Please describe your child's relationship with all family members (including closeness & conflict).

_____

_____

Have any of these relationships changed significantly in the recent past ? If yes, please describe.

_____

Have you had any big changes in your family in the last several years? (i.e. divorce, moving or changing homes, marriage, siblings moving out of the house, loss, etc.)

_____

_____

School History/Background

Daycare/Preschool: _____

Elementary School: _____

Middle School: _____

High School: _____

Has your child had learning or behavioral problems in school? If so, please describe problems and when they began (include information about grades repeated).

_____

_____

Has your child been involved in special education or received other supportive services in school? If so, please explain (i.e. 504, IEP, speech therapy, tutoring, special classes, etc.).

_____

_____

What has your child's attitude toward school and level of effort been in school?

_____

_____

Has the child missed school due to prolonged illness, suspension, skipping school/classes? If yes, please explain.

_____

What is your child's performance in school? Please include grades or subjects they struggle with:

_____

Social Development

Please describe your child's past and current peer relationships:

Ability to develop and maintain friendships: _____

Does your child have a best friend? _____

Does your child spend time with friends outside of school? _____

Recent change in friendships/peer group: _____

Are friends positive/negative influence?: _____

Risky behaviors with friends: _____

Is your child sexually active (Y/N)? _____

If yes, is your child pregnant? _____ using birth control? _____ practicing safe sex? _____

Leisure, Recreation & Areas of Interest

Describe leisure time activities, types of recreation enjoyed, and special areas of interest (i.e. hobbies, activities, interests, clubs, sports, etc.)

_____

_____

What do you like about your child? What are your child's strengths?

_____

_____

Religion & Spirituality

Religion/Spirituality of each parent: _____

Child's identified religion/spirituality is: _____

Is the family currently active in religious and/or spiritual practices? If so, please explain.

_____

Is there any part of your religious/spiritual beliefs that you believe to be important in the treatment of your child that you want your therapist to know about? If so, please describe:

_____

_____

Legal

Please circle any of the following in which the child has been involved:

Truancy	Sexual offense	Assault/Battery
Curfew Violations	Theft, Shoplifting	Traffic Violations
Running away	Substance use related crime	Other

If any of the above were circled (or other), please provide legal problem & dates:

_____

Have the child's parents or anyone else living in the home been arrested for any crimes (e.g. DUI, domestic violence, etc.)? If so, please explain (description, where, when, consequences):

_____

Has the child or his/her friends ever been involved with a gang (Y/N)? _____

Is the child currently on probation or under police supervision? If so, for what reason?

_____

If applicable, provide dates of supervision, name of probation officer and contact information.

_____

Has DCFS/Child protective services ever been involved with you or your family? If so, please describe.

_____

Substance Use/Abuse History

Has your child ever used alcohol (Y/N)? _____ Is use problematic? _____

If yes to either, please explain (how often, how much)? _____

Please circle any of the following drugs your child has used:

Tobacco	Marijuana	Cocaine	LSD, Acid
Inhalants	PCP, Angel Dust	Vaping	Misused prescription drugs

Other _____

Do you consider your child's drug use to be problematic? If yes, please explain.

_____

Substance Use/Abuse History of Family Members:

Do parents, caregivers, or other family members living in the home currently use:

	Family Member	How much?	How often?	Past/Current?
Alcohol				
Marijuana				
Illicit drugs				
Tobacco products				

Do any family members have a history of or current problematic behaviors with drugs or alcohol? If yes, please explain:

_____

If there is any other information you'd like your therapist to know about your child or that you think would support in their treatment, please describe below:

_____

_____

_____