CYPRESS
COUNSELING CENTER, P.C.

CHILD CLIENT HISTORY

Name: _____ DOB: _____

Address: _____ City/State/Zip: _____

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

_____

_____

In your opinion, what has caused these problems? _____

_____

How long have these problems been of concern? _____

Physical/Mental Health:

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

_____

_____

Please list previous outpatient therapy (therapist name, agency, dates, & type of therapy).

_____

_____

Describe psychiatric problems in the child's family/extended family (include hospitalizations).

_____

_____

History of personal and/or family verbal/physical/emotional/sexual abuse/neglect: _____

_____

Please check any of the following that your child has experienced:

☐ head injury (concussion, being hit in the head, car accident, stitches or sutures, etc.)
☐ unplanned aggressive behaviors ☐ short attention span ☐ loss of consciousness
☐ abnormal medical test results (CT, MRI, EEG, etc.) ☐ memory lapses

If you checked any of the above, please explain: _____

Describe any other significant health history regarding your child: _____

_____

List any medications your child is taking (form, amount and frequency; OTC and psychotropic).

_____

_____

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

_____

_____

Significant weight loss/gain? past month _____ past six months _____ past year _____

If yes, please describe. _____

Date of last physical examination, name of physician and results: _____

_____

Are immunizations current (Y/N)? _____ Does you child have any allergies (Y/N)? _____

If yes, please describe. _____

Describe significant health problems (e.g. accidents, illnesses, etc.) of child's parents and other family members or significant others (please list most recent first and dates).

_____

_____

Developmental History:

Pregnancy:
Planned (Y/N)? _____ Length: _____ Mother's weight gain: _____

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) (Y/N)? _____

If yes, please describe. _____

Pregnancy History:
Has mother had any miscarriages and/or abortions (Y/N)? _____

If yes, please describe. _____

Birth:
Length of labor: _____ Induced (Y/N)? _____ Caesarean (Y/N)? _____

Describe any physical or emotional complications with delivery: _____

_____

Baby's birth weight: _____ length: _____

Describe any complications for mother after birth: _____

_____

Length of hospitalization: Mother: _____ Baby: _____

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

Infancy/Toddlerhood (check all that apply):

☐ Breast fed	☐ Milk allergies	☐ Vomiting	☐ Diarrhea
☐ Bottle fed	☐ Rashes	☐ Colic	☐ Constipation

Describe any particular eating or feeding problems (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: _____

_____

Describe any past/current sleeping problems: _____

_____

Please indicate the age at which child completed the following:

Toilet trained _____ Dry during day _____ Dry during night _____

Took steps _____ Spoke words _____ Sentences _____

Weaned _____ Fed self _____ Dressed self _____

Rode 2-wheel bike _____ Tied shoe laces _____

Past/Current problems with any of the following (check all that apply):

☐ eyes	☐ ears	☐ thumb sucking	☐ head banging	☐ weight
☐ temper tantrums		☐ imaginary friends	☐ imaginary friends	☐ separation
☐ attachment to doll, stuffed animal, blanket, etc.			☐ sexual difficulties	☐ eating
☐ nervous habits (eye blinking, nail biting, etc.)			☐ masturbation	☐ fears
☐ day dreaming		☐ short attention span	☐ overactivity	☐ self-image
☐ taking constructive criticism		☐ sense of humor	☐ preoccupations	☐ nightmares

If yes, please describe when and the nature of the problem: _____

_____

Please indicate the age at which the following developed: Voice change _____

Breast development _____ Body hair _____ Menstruation _____

Family Environment:

Who does your child live with (name, age, relationship)? _____

_____

_____

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

_____

_____

Have any of these relationships changed significantly in the recent past (Y/N)? _____

If yes, please describe. _____

_____

Please list any deaths (family, peers, pets, etc.; name, relationship, date of death; response to death).

_____

_____

Work History & Financial Status:

Has the child been employed (Y/N)? _____ Most recent job: _____

Describe work habits (e.g. timeliness, length of employment, relationship with employer, etc.).

_____

List parents/step-parents recent job history (name, employer, position, length of employment).

_____

_____

_____

_____

School History/Background:

Please give name of school, grades attended and grades received. Current grade/yr: _____

Daycare/Preschool: _____

Elementary School: _____

Jr. High School: _____

High School: _____

Has the child had learning or behavior problems in school (Y/N)? _____

If so, please describe problems & when they began (include information about grades repeated).

_____

_____

Has the child been involved in special education (Y/N)? _____

If yes, please explain. _____

What has 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 (Y/N)? ____

If yes, please explain. _____

Social Development:

Please describe child's past and current peer relationships. Include child's ability to make/keep friends, if friends are a positive/negative influence, and if there has been a recent change in child's peer group.

_____

_____

Duration of best friendship: _____ Does the child date (Y/N)? _____

If yes, please explain. _____

Do you think your child is sexually active (Y/N)? _____

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

Current and/or past financial problems are/have been: _____

_____

Leisure, Recreation & Areas of Interest:

Describe leisure time activities, types of recreation enjoyed, and special areas of interest. Include social interactions with peers and family.

_____

_____

What do you like about the child? _____

_____

Religion & Spirituality:

Religion/Spirituality of each of child's parents is: _____

Child's religion/spirituality is: _____

Is the family currently active in religious and/or spiritual practices (Y/N)? _____

If yes, please explain. _____

_____

Legal:

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

☐ Truancy ☐ Running away ☐ Curfew Violations ☐ Theft, Shoplifting
☐ DUI, possession, use of illegal substance ☐ Assault/Battery
☐ Sexual Offenses ☐ Traffic Violations ☐ Other _____

If any of the above were checked, please provide legal problem & dates: _____

_____

Have the child's parents 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)? _____

If so, when and what charge(s)? _____

Has the child ever been exposed to or involved in any cult activities (Y/N)? _____

If yes, please explain: _____

Is the child currently on probation or under police supervision (Y/N)? _____

If yes, for what reason? _____

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

_____

Has DCFS ever been involved with you or your family (Y/N)? _____

If yes, 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 check any of the following drugs your child has used:
☐ Tobacco (smoke, chew, etc.) ☐ Marijuana ☐ Cocaine ☐ LSD, Acid
☐ Speed, Amphetamines ☐ Inhalants ☐ PCP, Angel Dust
☐ Misused prescription drugs ☐ Other _____

Do you consider your child's drug use to be problematic (Yes/No/Not Applicable)? _____

If yes, please explain. _____

Substance Use/Abuse History of Family Members:

Tobacco use: current _____ past _____ how long _____ how much _____

Current alcohol/drug use: daily _____ social _____ weekend _____ evening _____ binge _____

How much? _____

Drugs of choice: _____

Who do you usually drink/use with? _____

At what age did you begin drinking/using? _____

Last use (when, type, amount, where, with whom): _____

_____

Past history of alcohol/drug (AOD) use/abuse: _____

_____

Family history of AOD use/abuse: _____

How would your characterize yourself regarding AOD use/abuse (check all that apply)?

☐ social user ☐ problematic user ☐ alcoholic/addict ☐ abstinent
☐ controlled user ☐ recovering user ☐ other _____

Has anyone ever expressed concern about your alcohol/drug (AOD) use (Y/N)? _____

If yes, please explain. _____

History of AOD treatment or self-help involvement (where, when, type, duration, outcome):

_____

_____