Client ID#

CLIENT HISTORY
CHILDREN
(Age 17 and under)

CLIENT DEMOGRAPHICS					
Name			**Date of Birth**		
Name of Parent/ Guardian			**Date of Birth**		
Home Address					
City		**State**		**Zip Code**	
Home Phone			**Cell Phone**		
Is it OK for therapist to leave a message at these numbers?			**Yes No**		
Emergency Contact: Name & Phone #					
Person completing this form					
How did you hear about STLCFD?					
Your child's treatment goals are of highest importance to us. Please complete the following questions; your child's therapist will discuss these with you and your child during your first visit.					
Reason for bringing child to St. Louis Center for Family Development (STLCFD)? (How do you want the child's situation to be different after coming to STLCFD?)					

What are the child's strengths and talents?
Resources: What will help you and the child achieve the goals that bring you here?
Barriers: What might get in the way of achieving those goals?
What have you, the child, and others already done or tried to do to address the goals that bring you here?
PREGNANCY, DELIVERY, AND INFANCY INFORMATION

Did biological mother experience use any of the following substances during the pregnancy?			
Check this box if information is not available			
Alcohol	Yes No	Tranquilizers/sleeping pills	Yes No
Coffee / caffeine	Yes No	Anti-seizure medications	Yes No
Cigarettes	Yes No	Insulin or other diabetes treatments	Yes No
If yes to any of the above, please describe amount used and frequency (how often):			

Did biological mother experience any health problems or illness during pregnancy?	Yes No
Were there any pregnancy or delivery complications?	Yes No
Did the infant require specialized medical attention or tests at birth?	Yes No
If yes to any of the above, please describe:	

EARLY CHILDHOOD (PRE-KINDERGARTEN) DEVELOPMENT	
One or more major developmental milestones were **NOT** met within normal limits (sitting up, walking, first words, speaks in sentences, etc.)?	Yes No
Did pediatrician, other professionals, or parent(s)/guardian(s) have any concerns about the child's early development?	Yes No
Did the child experience any medical procedures, surgeries, or invasive treatments (tubes, chronic ear infections, etc)?	Yes No
If yes to any of the above, please describe:	

CURRENT HEALTH INFORMATION

Pediatrician/Primary Care Physician	
Date of Last Contact	
Date of most recent Well Child or Annual Exam	
Are the current immunizations up to date?	Yes No
Is the child sexually Active?	Yes No

Does child have currently or in the past:

Allergies	Sleep Problems	Speech/language Problems	Thyroid Problems
Asthma	Contagious Disease	Vision Problems	Physical Challenges
Nutritional/feeding Problems	Head Injury	Surgeries	Diabetes
Appetite Problems	Loss of Consciousness	Hospitalizations	Other
Eating Disorder	Convulsions/seizures	Heart Conditions	None of the Above
Gastrointestinal Problems, Stomachaches	Major Accidents or Injuries	High Blood Pressure	
Dental Problems	Hearing Problems	Headaches	

Comments about items checked above:

Does child have any disabilities not noted thus far?	Yes No

If yes, please describe:

Please list all current prescribed &/or over-the counter drugs/medications (include psychiatric medication)

Medication	Dosage	What is the medicine treating	Prescribed by

PREVIOUS COUNSELING/PSYCHOTHERAPY				
Has the child been seen previously for evaluation and/or treatment of emotional or behavioral concerns?	Yes No			
Check if applicable	Inpatient	Day Treatment	Substance Abuse Program	Outpatient
	Psychological Testing	Psychiatric Evaluation	Partial Hospitalization	Other

Name of Facility/ Provider	**Dates**	**Type of Treatment**	**Problem Area**

Has the child:		
Made a suicide attempt(s)?	Yes No	If yes, date of last attempt:_______________ Method of attempt:_____________________
Expressed homicidal thoughts?	Yes No	If yes, date of last thoughts:______________
Had episodes of explosive anger?	Yes No	
Is the child currently expressing homicidal/suicidal feelings?	Yes No	

If yes to any of the above please describe:

CURRENT SYMPTOMS (as identified by parents)

Difficulty sustaining attention		Excessive Worry		Sadness		Exposure to traumatic event(s)	
Careless mistakes		Restlessness		Hopelessness		Recurrent or intrusive thoughts	
Difficulty listening		Easily fatigued		Excessive guilt		Distressing dreams of the event	
Difficulty following instruction		Difficulty concentrating		Suicidal thoughts		Flashbacks	
Difficulty with organization		Irritability		Sleep disturbance		Difficulty falling/staying asleep	
Often lose items		Muscle tension		Changes in appetite		Startle Easily	
Forgetful		Sleep disturbance		Agitation		Difficulties with spouse/ partner	
Fidgety		Frequent headaches		Decrease in pleasurable activities		Difficulties with family and/ or friends	
Often "on the go"		Frequent Stomachaches		Extreme energy		Excessive thoughts about food, weight, or dieting	
Talk excessively		Vomiting		Decreased need for sleep		Food group avoidance	
Interrupts others		Diarrhea		Racing thoughts		Emotional overeating	

FAMILY INFORMATION

Child place of birth?				
Was child adopted?	Yes No			
Does the child identify as	African American	Caucasian	Native American	Hispanic
	Latino	Asian	Bi-racial	Other: ______________

Are the child parents	Married	Partnered	Separated	Divorced	Other: ____________
If separated or divorced, please describe visitation or co-parenting schedule:					

HOUSEHOLD COMPOSITION (INCLUDE ALL PERSONS IN RESIDENCE INCLUDING CLIENT MENTIONED ABOVE)					
Name	**Gender**	**Race**	**Relationship**	**Age**	**Comments**
Are there any family members with mental health concerns (anxiety, depression, etc.)?					Yes No
If yes, please describe:					
Are there any past or current substance abuse issues with his/her family members?					Yes No

If yes, please describe:

Has the child's parent(s) or caregiver(s) ever experienced a traumatic event(s)?	Yes No
If yes, please describe:	
Describe child's relationship with her/his family members (e.g., parents, siblings, step-parents, etc.):	

Does the child have	No Friends	Only Acquaintances	Acquaintances & Friends	How many close friends? _________

Has the child been abused or assaulted	Physically	Sexually	Emotionally and/or Verbally	Suspected	None of these

Has the child	Been Bullied	Been a Bully	Neither
If yes to either question above, please describe:			

EDUCATIONAL INFORMATION
Schools Attended

School Name	Grades Attended	Favorite Subjects	Least Favorite Subjects	Average Grades	Comments

What are the child's average grades in the past 6 months?	A's B's C's D's F's
Is the child performing to his or her potential at school?	Yes No
Does child currently enjoy school?	Yes No Unknown

Comments:

Has the child had current or past?	Individualized Education Plan (IEP)	Tutoring	School Suspensions	School Expulsions	None of these

If yes to any of the above, please describe:

NON-SCHOOL ACTIVITIES

How does the child spend non-school time (hobbies, activities, recreational, musical, etc. preferences):

RELIGION/SPIRITUALITY

Does the child identify as:	Protestant	Catholic	Jewish	Buddhist	Hindu
	Muslim	Evangelical	Agnostic	Atheist	Other_________

Presently active in religion/ spirituality?	Yes No N/A

LEGAL INFORMATION

Has the child (currently and/or in the past):
- Had difficulty or contact with police?
- Been convicted of a crime?
- Been on probation?
- No history of legal problems

If any legal problems, please describe:

SUBSTANCE USE: Please consult with child and complete the chart below; circle any of the substances listed if child has used them in the past 48 hours.

			Please complete these questions for substance use						
Category of Substance	Current Use?	Ever used?	Amount and Frequency of Use (e.g., 8 beers/day)	Maximum amount used	Use has led to problems (school, social, health, legal)	Doesn't do what's expected of him/her due to use	Others have concern about child/ teen's use	Have urges to use, or tried to cut down or stop	With-drawal symptoms
Alcohol	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Stimulant	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Cocaine	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Tranquilizer	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Barbiturate	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Marijuana	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Opioid	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Hallucinogen	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Prescribed	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Nicotine	N Y	N Y			N Y	N Y	N Y	N Y	N Y
Caffeine	N Y	N Y			N Y	N Y	N Y	N Y	N Y

Other	N Y	N Y			N Y	N Y	N Y	N Y	N Y

Does the child travel with driver(s) under the influence?	No Yes
Does the teen drive after substance use?	No Yes
Does the child see negative consequences to substance use?	No Yes

ADDITIONAL INFORMATION (You think therapist should know.)

01.13