St. Louis CENTER FOR Family Development LLC

Client ID# _____

CLIENT HISTORY
CHILDREN
(Age 17 and under)

CLIENT DEMOGRAPHICS			
Name		**Date of Birth**	
Name of Legal Guardian		**Date of Birth**	
Name of Legal Guardian		**Date of Birth**	
Primary Phone #			
Is it OK for therapist to leave a message at this number? ☐ **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?)

When did you first start to have concerns for the child?

What are the child's strengths and talents?

PREVIOUS COUNSELING/PSYCHOTHERAPY				
Has the child been seen previously for evaluation and/or treatment of emotional or behavioral concerns?			☐ Yes ☐ No	
Check if applicable	☐ Psychiatric Treatment	☐ Counseling	☐ Group Therapy	☐ Family Therapy
	☐ Behavioral Interventions	☐ Partial Hospitalization	☐ Intensive Outpatient Program	☐ Inpatient

Dates	Name of Provider/Facility	Reasons for Going	Progress Noted (no change, better, worse)

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:

Please list previous diagnoses made by other providers: ☐ Check if no previous diagnoses

Previous Diagnoses	Approximate Age Diagnosed

MEDICATION	
Is your child currently taking psychiatric medications?	☐ Yes ☐ No
If yes, please provide the provider's name and phone number:	**Name:** _____ **Phone:** _____

Please list all current medications (both psychiatric AND medical):		
Medication	**Dosage**	**Progress Noted (no change, better, worse)**

HEALTH INFORMATION

Please list all past and current medical conditions: ☐ Check if no past or current conditions

Condition	Treating Doctor

Has the child experienced any medical procedures, surgeries, or invasive treatments (tubes, chronic ear infections, etc)?	☐ Yes ☐ No
Does the child have any vision or eye problems?	☐ Yes ☐ No
Does the child have any hearing problems?	☐ Yes ☐ No
Does the child have allergies?	☐ Yes ☐ No
If yes to any of the above, please describe:	
Does child have any disabilities not noted thus far?	☐ Yes ☐ No
If yes, please describe:	

FAMILY INFORMATION

Current Living Situation: Please provide information for household/family members currently living in the home and immediate family members living outside the home.

Name	Inside or Outside the home	Relationship to child	Gender	Age	Comments

Family Mental Health/Social History: 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:	

Family Relationships: Describe the child's relationship with her/his family members (e.g., parents, siblings, step-parents, etc.)

Are the child parents	☐ Married	☐ Partnered	☐ Separated	☐ Divorced	☐ Other: _____

If separated or divorced, please describe visitation or co-parenting schedule:

PRENATAL DEVELOPMENT AND BIRTH HISTORY

Was child adopted?	☐ Yes ☐ No		
☐ Check this box if prenatal information is not available			
Did biological mother use any of the following substances during the pregnancy?			
Caffeine	☐ Yes ☐ No	Recreational drugs	☐ Yes ☐ No
Tobacco	☐ Yes ☐ No	Prescription medication/medical treatment other than routine prenatal care	☐ Yes ☐ No
Alcohol	☐ Yes ☐ No	Other	☐ 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:	

DEVELOPMENTAL HISTORY

Were major developmental milestones met within normal limits (sitting up, walking, first words, speaks in sentences, etc.)?	☐ Yes ☐ No
If no, please describe:	

EDUCATIONAL HISTORY

Name of child's current school	
Child's current grade in school (e.g., 8th)	
What are the child's average grades in the past 6 months?	☐ A's ☐ B's ☐ C's ☐ D's ☐ F's
Have there been significant changes in the child's performance and/or behaviors in school?	☐ Yes ☐ No
Is the child performing to his or her potential at school?	☐ Yes ☐ No
Comments:	
Does the child have any learning disabilities?	☐ Yes ☐ No
If yes please describe:	

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:					

SOCIAL HISTORY AND LIFESTYLE HEALTH

Does the child have	☐ No Friends	☐ Only Acquaintances	☐ Acquaintances & Friends	How many close friends? _____
Has the child	☐ Been Bullied	☐ Been a Bully	☐ Neither	
If yes to either question above, please describe:				

Do you have any current concerns regarding the child's sleep habits?	☐ Yes ☐ No
Do you have any concerns regarding the child's eating habits or changes in weight?	☐ Yes ☐ No
If yes to either question above, please describe:	
How does the child spend non-school time (hobbies, activities, recreational, musical, etc. preferences):	

SUBSTANCE USE: Please complete these questions for substance use.

Category of Substance	Current Use?	Ever used?	Amount and Frequency of Use (e.g., 8 beers/day)
Caffeine	☐Y ☐N	☐Y ☐N	
Tobacco	☐Y ☐N	☐Y ☐N	
Alcohol	☐Y ☐N	☐Y ☐N	
Prescribed (to get high)	☐Y ☐N	☐Y ☐N	
Recreational (including marijuana)	☐Y ☐N	☐Y ☐N	
Other	☐Y ☐N	☐Y ☐N	

Has use led to problems (e.g., risky behaviors, problems at school, health issues, etc.)?	☐ Yes ☐ No
If yes, please describe:	

TRAUMA HISTORY

Has the child experienced any of the following:

☐ Death of family member and/or significant person	☐ Serious accident
☐ Physical abuse	☐ Significant illness or injury
☐ Sexual abuse or sexual assault	☐ Natural disaster (e.g., fire, tornado, earthquake)
☐ Emotional abuse	☐ Other traumatic event: _____
☐ Neglect	☐ None
☐ Exposure to violence	

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:

SPIRITUAL ORIENTATION					
Does the child identify as:	☐ Protestant	☐ Catholic	☐ Jewish	☐ Buddhist	☐ Hindu
	☐ Muslim	☐ Evangelical	☐ Agnostic	☐ Atheist	☐ Other_____
How active is the child in his/her spiritual life?	☐ Not at all Active	☐ Somewhat Active	☐ Very Active		

ADDITIONAL INFORMATION (You think therapist should know.)