Client History Form

Mental Health:

Have you had a mental health diagnosis or services before? ___________________________________

If yes, where? ____

Diagnoses: ____

Please describe any family history of mental health problems. ___________________________________

____

Medical:

Past/Present medical concerns: ____

____

Primary Physician: ____________________________________ Date of last exam:________________

Current medication list:

1. __________________ Dosage / Freq ___________ Start date __________ Purpose____________
2. __________________ Dosage / Freq ___________ Start date __________ Purpose____________
3. __________________ Dosage / Freq ___________ Start date __________ Purpose____________
4. __________________ Dosage / Freq ___________ Start date __________ Purpose____________

Prescribed by: ____

Have you ever been hospitalized? If yes, when and why? ____

____

Have you ever had a concussion? If yes, when: ____

Allergies: ____

Please describe any family history of significant medical issues ___________________________________

____

Developmental History:

Who was your primary caretaker during your first 5 years of life? _________________________________

Any illnesses or complications during pregnancy? ____

Any complications during delivery? (e.g. premature, breech, etc.) _________________________________

Any maternal drug/alcohol use during pregnancy? ____

Any delays in meeting developmental milestones? (e.g. walking, talking, etc.) _______________________

____

Education:

Are you in school? If so, which school do you attend? ____

Last year of school completed/current grade: ____

Do you, or did you, experience any academic problems while in school? If yes, please describe:

____

Do you, or did you, need any additional support in the following areas? If yes, please describe:

- ☐ None
- ☐ Reading ____
- ☐ Writing ____
- ☐ Math ____
- ☐ Hearing/understanding spoken language:____
- ☐ Speech ____
- ☐ Getting along with teachers ____
- ☐ Getting along with classmates ____
- ☐ Attendance/ skipping class ____
- ☐ Attention Deficit/Hyperactivity (ADHD) ____
- ☐ Other ____

Have you ever received special education services? If yes, which type? ___________________________

Social History:

Please list your parents, including biological, step and adoptive parents:

____

____

Please list your siblings, their ages, and your relationship to them (biological, step, half, etc): __________

____

Do you have a partner? Please list name and age:

____

Do you have any children? Please list names and ages

____

Who do you live with? ____

Who is your current support network? (friends, relatives, others): _________________________________

____

Do you practice any religion or spiritual practices? ____

What are your hobbies and interests? ____

Do you drink alcohol? If yes, how much/often? ____

Do you use recreational drugs? If yes, how much/often? ____

Have you, or someone in your household, ever been exposed to any of the following?

- ☐ Verbal/emotional abuse
- ☐ Physical abuse
- ☐ Witness to domestic violence
- ☐ Sexual abuse or molestation
- ☐ Neglect
- ☐ Substance abuse
- ☐ Chronic illness
- ☐ Impaired caregiver (mental health, physical health, chemical use)
- ☐ Other traumatic event (fire, natural disaster)

Please list your therapy goals: ____

____

____

Is there any other information regarding you or your family you'd like to share with your therapist that is not covered on this form? ____

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