MINOR CLIENT HISTORY

CLIENT NAME: _____ **DATE:** _____

FAMILY & SOCIAL BACKGROUND:

Please list and describe your child's or teen's current family members (immediate, extended, adopted, etc.)

NAME	RELATIONSHIP	AGE	OCCUPATION	COMMENT(S)
1)				
QUALITY OF RELATIONSHIP:	*POOR FAIR NEUTRAL GOOD VERY GOOD ESTRANGED*			
2)				
QUALITY OF RELATIONSHIP:	*POOR FAIR NEUTRAL GOOD VERY GOOD ESTRANGED*			
3)				
QUALITY OF RELATIONSHIP:	*POOR FAIR NEUTRAL GOOD VERY GOOD ESTRANGED*			
4)				
QUALITY OF RELATIONSHIP:	*POOR FAIR NEUTRAL GOOD VERY GOOD ESTRANGED*			
5)				
QUALITY OF RELATIONSHIP:	*POOR FAIR NEUTRAL GOOD VERY GOOD ESTRANGED*			
6)				
QUALITY OF RELATIONSHIP:	*POOR FAIR NEUTRAL GOOD VERY GOOD ESTRANGED*			
7)				
QUALITY OF RELATIONSHIP:	*POOR FAIR NEUTRAL GOOD VERY GOOD ESTRANGED*			

Were they adopted? ☐ YES ☐ NO If yes, what age? ___

Did their parents ever divorce? ☐ YES ☐ NO If yes, what age? ___

Were they ever in foster or residential care? ☐ YES ☐ NO If yes, what age? ___

Have they ever experienced death of someone close? ☐ YES ☐ NO

If yes, please describe: _____

Please indicate if your child / teen or a close family member experienced one or more of the following:

EXPERIENCE	CHILD	OTHER	RELATIONSHIP	COMMENT(S)
Emotional Abuse				
Physical Abuse				
Sexual Abuse				
Domestic Violence				
Neglect				
Substance Abuse				
Serious Illness				
Accident / Injury				
Crime Victimization				
Financial Problems				
Military Combat				
Homelessness				
Discrimination				
School / Workplace Bullying				
Head Injury / Concussion				
Other:				

Please describe any relevant or important information regarding your ethnic / cultural background:

_____

_____

_____

_____

Do you have any specific ethnic / cultural concerns? ☐ YES ☐ NO

*If yes, please describe:*_____

Religious / spiritual background: _____

Current religious / spiritual activity:_____

Do you have any spiritual concerns now? _____

Please list any of your child's or teen's relevant or important interests / activities / hobbies:

_____

_____

_____

_____

Do they believe they have enough time for their interests or non-work activity? ☐ YES ☐ NO

EDUCATIONAL HISTORY:

Please list all of the schools your child / teen has attended, starting with the most current or recent:

DATES ATTENDED	SCHOOL NAME	GRADES / GPA	GRADUATE?	ANY CONCERNS?

List any special education placements: _____

List any suspensions/expulsions: _____

List any future school plans: _____

List any learning disabilities: _____

List any educational concerns: _____

EMPLOYMENT HISTORY:

Check One: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Other:_____

Please list all of the jobs your child / teen has held, starting with the most current or recent:

DATES EMPLOYED	EMPLOYER	JOB TITLE	REASON FOR LEAVING

Are they looking for work or new job now? ☐ YES ☐ NO ☐ N/A

Do they have any employment problems now? ☐ YES ☐ NO ☐ N/A

If yes, please describe: _____

Have they ever been fired? ☐ YES ☐ NO ☐ N/A

If yes, please describe: _____

Do they have any military experience? ☐ YES ☐ NO ☐ N/A

Branch:_____ Current/Highest Rank:_____

Discharge Date:_____ Type of Discharge:_____

LEGAL HISTORY:

Please list and describe any current or past arrests, court appearances, or other legal concerns your for child or teen:

ARREST DATE	CHARGE	CONVICTED?	SENTENCE

Are they currently on Probation? ☐ YES ☐ NO **If yes, end date:** _____

Are they currently on Parole? ☐ YES ☐ NO **If yes, end date:** _____

Are they involved in any lawsuits? ☐ YES ☐ NO **If yes, describe:**_____

Any upcoming court dates? ☐ YES ☐ NO **If yes, describe:**_____

Are parents currently involved in divorce proceedings? ☐ YES ☐ NO

Are parents currently involved in custody proceedings? ☐ YES ☐ NO

If yes to any above, describe outstanding legal concerns: _____

MENTAL HEALTH & PHYSICAL HEALTH TREATMENT HISTORY:

Have they ever been HOSPITALIZED in a psychiatric hospital? ☐ YES ☐ NO

DATES OF ADMISSION	HOSPITAL	REASON FOR ADMISSION

Have they received any OUTPATIENT counseling or psychotherapy? ☐ YES ☐ NO

DATES OF TREATMENT	LOCATION / AGENCY	REASON FOR TREATMENT

Have they ever been involved in any SELF-HELP or SUPPORT GROUPS? ☐ YES ☐ NO
(e.g., Alcoholics Anonymous, Al-Anon, Alateen, etc.)

DATES OF INVOLVEMENT	GROUP	REASON FOR INVOLVEMENT

Please list any medications, including psychiatric meds:

NAME OF MEDICATION	PRESCRIBER	REASON

Did they previously take any previous psychiatric medications at any time? ☐ YES ☐ NO
If yes, please describe what and when: _____
_____

Please check any of the following concerns that apply to your child/teen now or within the past:

☐ Depression
☐ Mood swings
☐ Hopelessness
☐ Guilt/shame
☐ Loneliness
☐ Loss of appetite
☐ Overeating/bingeing
☐ Sleep disturbance
☐ Nightmares
☐ Thoughts of harming self
☐ Thoughts of harming others
☐ Suicide attempts/injuries
☐ Cutting
☐ Hearing voices
☐ Seeing things others do not
☐ Unusual thoughts
☐ Other:_____

☐ Increased alcohol use
☐ Increased drug usage
☐ Blackouts/memory loss
☐ Withdrawal symptoms
☐ Target of bullies
☐ Bullies/teases others
☐ Gambling
☐ Poor impulse control
☐ Poor anger control
☐ Yelling at others
☐ Hitting others
☐ Breaking objects
☐ Feeling controlled
☐ Feeling suspicious
☐ Pessimism
☐ Phobias/Fears
☐ Other:_____

☐ Nervous/Anxious
☐ Panic attacks
☐ Poor concentration
☐ Confusion
☐ Disorganized
☐ Racing thoughts
☐ Fear of dying
☐ Job stress
☐ Decreased activity
☐ Not seeing friends
☐ School problems
☐ Sexual problems
☐ Obsessions/Compulsions
☐ Autism/Asperger's
☐ Developmental delays
☐ Traumatic Brain Injury
☐ Other:_____

Please explain any checked items: _____
_____
_____

Have they ever attempted to commit SUICIDE or serious self-harm? ☐ YES ☐ NO
If yes: How many times? _____ When? _____
Method(s) of Attempt(s):_____
Has anyone in your family attempted suicide? ☐ YES ☐ NO If yes, who? _____
Has anyone in your family committed suicide? ☐ YES ☐ NO If yes, who? _____
Does your child or teen have any current medical problems? ☐ YES ☐ NO
*If yes, please list and describe below:*_____
_____
_____
_____

Does your child or teen have any history of major medical interventions or surgery? ☐ YES ☐ NO
*If yes, please list and describe below:*_____
_____
_____

Does your child or teen have any history of head injury or traumatic brain injury? ☐ YES ☐ NO
*If yes, please list when and how:*_____
_____
_____

Does your child or teen have any history of loss of consciousness? ☐ YES ☐ NO
*If yes, please list when and how:*_____
_____
_____

ALCOHOL AND DRUG HISTORY:

Please list and describe any substance abuse and/or substance treatment history for your child or teen.

During the last 12 months…

Did they ever experience blackouts (i.e., memory lapses) when drinking?	☐ YES ☐ NO
Did they ever drink more than you planned to drink?	☐ YES ☐ NO
Did they use larger amounts of substances or use them for a longer time than they planned or intended?	☐ YES ☐ NO
Did they try to cut down on their substance use, but were unable to do it?	☐ YES ☐ NO
Did they spend a lot of time getting substances, using them, or recovering from their use?	☐ YES ☐ NO
Did they get so high or sick from using substances that it kept them from doing work, going to school, or other responsibilities?	☐ YES ☐ NO
Did they get so high or sick from substances that it caused an accident or put them or others in danger?	☐ YES ☐ NO

Did they spend less time at work, school, or with friends so that they could use substances? ☐ YES ☐ NO

Did their substance use cause emotional or psychological problems? ☐ YES ☐ NO

Did their substance use cause problems with family, friends, work, or police? ☐ YES ☐ NO

Did their substance use cause physical health or medical problems? ☐ YES ☐ NO

Did they increase the amount of a substance so that they could get the same effect? ☐ YES ☐ NO

Did they ever keep using a substance to avoid withdrawal symptoms or keep from getting sick? ☐ YES ☐ NO

Did they get sick or have withdrawal symptoms when they quit or missed taking a substance? ☐ YES ☐ NO

Have they ever experienced an overdose? ☐ YES ☐ NO

Has anyone ever commented or been concerned about their drinking or drug use? ☐ YES ☐ NO

Has drinking or drug use ever caused problems for them in any of the following areas?

☐ Family ☐ Employment ☐ Legal ☐ Emotional
☐ Social ☐ Financial ☐ Behavior ☐ Physical

Please complete the following chart regarding any substance use by your child in the past 12 months:

TYPE OF DRUG	How often did you use each drug in the past 12 months?					Age of 1st use (if applicable)
	Never	Only a few times	1 to 3 times per month	1 to 5 times per week	Almost daily	
Caffeine						
Nicotine/Tobacco						
Alcohol						
Marijuana						
Cocaine (powder)						
Cocaine (crack)						
Heroin						
Methadone						
Suboxone						
Pain Medication						
Ecstasy/MDMA						
Muscle Relaxers						
Anti-anxiety meds						
Inhalants						
PCP						
LSD						
(Meth)amphetamine						
Sleeping pills						
Diet Pills						
Steroids						

Have they ever received any INPATIENT alcohol or drug treatment? ☐ YES ☐ NO
If yes, where/when: _____

Have they ever received any OUTPATIENT alcohol or drug treatment? ☐ YES ☐ NO
If yes, where/when: _____

Has any family member or loved one ever had a drinking or drug problem? ☐ YES ☐ NO
If yes, please describe who / what problem(s): _____

Any other relevant information that you believe is important to your child's or teen's treatment:_____

I verify the above information is true and complete to the best of my knowledge. I understand that any withholding of information, omissions, or misinformation may affect the course of my and/or child's response to any treatment. I agree to inform my healthcare provider(s) of any relevant and/or significant changes as they occur throughout my and/or my child's course of treatment.

_____ _____
Client Signature (if 14 or older) **Date**

_____ _____
Client Representative Signature (if under 18) **Date**

_____ _____
Client Representative Signature (if under 18) **Date**

_____ _____
Healthcare Provider **Date**