

**Child & Family Guidance Center of Texoma**  
**CLIENT HISTORY FORM ages 3-11**

To be completed by parent or guardian

**This confidential information will help your therapist know more about your child.**

NAME \_\_\_\_\_

DATE OF BIRTH/AGE \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

ETHNICITY \_\_\_\_\_

SEX    F                      M

Form completed by \_\_\_\_\_

Your relationship to child \_\_\_\_\_

**CHILD'S DEVELOPMENTAL HISTORY:**

1. Was the pregnancy planned or unplanned?    Yes    No    Was pregnancy full-term?    Yes    No

2. Please check any of the following which occurred during pregnancy:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Prenatal care     | <input type="checkbox"/> Good Nutrition   | <input type="checkbox"/> Accident                 |
| <input type="checkbox"/> Chronic disease   | <input type="checkbox"/> Nervous/Worried  | <input type="checkbox"/> Headaches                |
| <input type="checkbox"/> Measles           | <input type="checkbox"/> Over/Underweight | <input type="checkbox"/> Unusual stresses         |
| <input type="checkbox"/> Medications taken | <input type="checkbox"/> Toxemia          | <input type="checkbox"/> Narcotics/alcohol intake |
| <input type="checkbox"/> Vomiting/Nausea   | <input type="checkbox"/> Flu/high fevers  | <input type="checkbox"/> Infections               |

3. Did mother feel depressed after the baby's birth?                      Yes                      NO

4. How well do you believe that mother and baby bonded after baby's birth?

**DEVELOPMENTAL MILESTONES: Please rate child on EACH of the following, using a scale of:**

**A=average; S=slower than average; F=faster than average**

- |                                       |  |                                       |   |
|---------------------------------------|--|---------------------------------------|---|
| <input type="checkbox"/> Smiled       | <input type="checkbox"/> Sat up without support    | <input type="checkbox"/> Stood        | <input type="checkbox"/> Walked         |
| <input type="checkbox"/> Fed self     | <input type="checkbox"/> Said 1 <sup>st</sup> word | <input type="checkbox"/> Said phrases | <input type="checkbox"/> Toilet Trained |
| <input type="checkbox"/> Dressed self |  |                                       |   |

**Please explain any milestone rated other than A (average):**

5. During the child's first year of life, was **anything** present in the life of the mother or father which caused unhappiness or anxiety, or which placed either parent under special strain (even if the event had nothing to do with the baby)? If so, please explain

6. Have any difficult or unusual discipline problems occurred in the life of the child? If so, please explain.

**PRESENTING PROBLEM:**

Describe problems your child is having: \_\_\_\_\_

When did problem(s) begin, and what has contributed to the problem(s)? \_\_\_\_\_

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**TREATMENT HISTORY:**

- 1. Has your child been in counseling before? **If so, with whom?**  
**When?** **For how long?**
- 2. What was the primary concern?
- 3. How helpful was therapy?
- 4. Has your child ever been hospitalized for psychological problems? **Yes** **No**  
If so, **When?** **Where?** **For How Long?**
- 5. Is your child currently taking **any** medications? If yes, what Rx

**DEPRESSION:** Please circle those that apply. **Does your child:**

- a. **Sleep** more or less than usual; b. **Eat** more or less than usual; c. **Cry** more easily than in the past; d. **Lack energy** or complain of always feeling **tired**; e. **Seem preoccupied** with life events; f. **Want to be alone** more than usual; g. **Lack interest** in activities that once brought pleasure?

**FAMILY HISTORY:** Please list **all persons** living in your household:

<u>Name</u>	<u>Age</u>	<u>Relationship to Child</u>	<u>Relationship between child/client and the named person:</u>
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

**CONCERNS:** Please list **any/all family member(s) or people** living with you who have experienced any of the following: **NAME(S) &/or RELATIONSHIP TO CLIENT**

- 1. Mental Illness
  - 2. Depression
  - 3. Neglect
  - 4. Physical Abuse
  - 5. Sexual Abuse
  - 6. Emotional/Verbal Abuse
  - 7. Alcohol Abuse
  - 8. Drug Abuse
  - 9. Sexual Dysfunction
  - 10. Financial Difficulty
  - 11. **Threatened/Attempted Suicide**
  - 12. Experienced/Witnessed Family Violence
  - 13. **PLEASE LIST ANYTHING ABOUT YOUR FAMILY’S LIFESTYLE THAT YOU THINK MIGHT BE HELPFUL FOR THE THERAPIST TO KNOW:**
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