

Name: _____ Date of Birth: _____ Date: _____

Family and Relationships

1. **Family/Home Information** (list all people living in home, including client)

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who do you feel supports you? (include extended family, friends, teachers etc.)

What do you do together as a family? _____

What do you like about your family? What are its strengths?

Personal Activities, Strengths, Interests, etc. (What do you like about yourself? What do you feel you do well?
Parents/ what does he/she do well?) _____

How do you usually manage stress in your life?

2. **Family Information:**

(Include circumstances of living situation; marriage/divorce; significant loses; whereabouts/contact with non-custodial parent; recent refugee or immigrant, etc. Use dates if known.)

3. **Developmental History:** (document as much as possible i.e., Was parent a teen? Complication with pregnancy or birth, Drug/Alcohol use during pregnancy, Did mother suffer from post-partum depression, Any difficulties in bonding, Was there a significant separation from the child during the first five years)

4. **Cultural History:** (include: gang history, foster home history, immigrant or refugee status, degree of acculturation etc.)

5. **Abuse History:**

Has client been a victim of:

- Sexual Abuse Yes No
- Physical Abuse Yes No
- Emotional Abuse Yes No
- Neglect Yes No

If Yes to any of the above, please describe in detail: (incidents/dates/reported & investigated? CPS Open Cases?)

6. Counseling History

List any counseling the client or client’s family has received, including the agency, dates, and focus.

What was helpful about counseling? _____

7. School

Current School Status:

- in school not attending H.S. graduate suspended dropped out
- GED Alternative Program H.S. Re-entry Program

School attending: _____ Present Grade level: _____

School IEP/Teacher name: _____

Learning disabilities: Yes No

Special Ed: Yes No

Describe school performance/behavior (current/past) _____

8. Drug/Alcohol History

Describe frequency of past and present use; prior treatment history and family history of drug/alcohol use.

9. Legal Involvement: (Include any past or current history)

Name of Parole Officer, Probation Officer, or Diversion Monitor:

Any family members convicted of crime: _____

10. Self Destructive Behavior

Describe the circumstance of any suicidal ideation, attempts, self-mutilation, etc.:

Have other family members attempted or completed suicide? _____

Who / When: _____

Statement of concerns and goals in client's own words: (Why are you here? What have you been doing to address these concerns? What do you want to change?)

Please check any of the following feelings or symptoms that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> depressed, withdrawn | <input type="checkbox"/> poor appetite |
| <input type="checkbox"/> feel inferior, not good enough | <input type="checkbox"/> food binging |
| <input type="checkbox"/> hopelessness | <input type="checkbox"/> food purging |
| <input type="checkbox"/> crying spells | <input type="checkbox"/> difficulty making decisions |
| <input type="checkbox"/> mood swings | <input type="checkbox"/> feeling guilty |
| <input type="checkbox"/> poor concentration | <input type="checkbox"/> unable to relax |
| <input type="checkbox"/> poor memory | <input type="checkbox"/> unable to enjoy myself |
| <input type="checkbox"/> low energy | <input type="checkbox"/> memory lapse/loss |
| <input type="checkbox"/> anxious/worried | <input type="checkbox"/> fearing a loss of control |
| <input type="checkbox"/> specific fears | <input type="checkbox"/> thoughts of harming or killing myself |
| <input type="checkbox"/> panic attacks | <input type="checkbox"/> self harm/cutting |
| <input type="checkbox"/> sleep problems | <input type="checkbox"/> impulsivity |
| <input type="checkbox"/> sleeping more than usual | <input type="checkbox"/> fighting or bullying |
| <input type="checkbox"/> relationship problems | <input type="checkbox"/> running away |
| <input type="checkbox"/> feeling detached from others | <input type="checkbox"/> lying |
| <input type="checkbox"/> angry or irritable | <input type="checkbox"/> lack of interest in previously enjoyed activities |

Counselor Signature: _____ Date: _____

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

