CLIENT HISTORY FORM

Client Name _____ Date_____

Birthdate _____ Age_____ Sex _____

Others in Household:	Relationship to client	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Briefly state your main concerns: _____

_____

Have any of your blood relatives experienced similar problems? Please list if any: _____

_____

MEDICAL HISTORY Please note the age and any other pertinent information. Use back if necessary.

Childhood diseases: _____

Operations: _____

Other hospitalizations: _____

Head injuries:_____

Convulsions/seizures: _____

Persistent high fevers: _____

Eye problems: _____

Tics (eye blinking, sniffing, or any repetitive movement): _____

Ear problems: _____

Allergies or asthma: _____

Sleep problems (restless, night waking, sleepwalking): _____

Describe your appetite: _____

Please list other doctors or professionals consulted: _____

Current medications and dose: _____

Current or Previous Counseling: _____

_____

FAMILY/SOCIAL HISTORY

Include any brothers or sisters you have/had as well as your natural parents. Be sure to include PAST or PRESENT behavior.

Birth Mother History (Check all that apply)

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Drug Usage
__ Domestic Violence
__ Mental Illness
__Homosexuality

Birth Father History (Check all that apply)

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Drug Usage
__ Domestic Violence
__ Mental Illness
__Homosexuality

Sibling History (Check all that apply)

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Drug Usage
__ Domestic Violence
__ Mental Illness
__Homosexuality

Sibling History (Check all that apply)

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Drug Usage
__ Domestic Violence
__ Mental Illness
__Homosexuality

Sibling History (Check all that apply)

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Drug Usage
__ Domestic Violence
__ Mental Illness
__Homosexuality

Sibling History (Check all that apply)

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Drug Usage
__ Domestic Violence
__ Mental Illness
__Homosexuality

Which family member has the best relationship with the patient?_______

MOOD RATING SCALE

Name _____
Carefully consider which apply to you. Circle the corresponding number.

Depressed mood (sad, gloomy, forlorn)
1. None
2. Mild
3. Moderate (brief periods of unhappiness or no emotion
4. Severe (often looks sad or withdrawn)

Weeping
1. None
2. Normal for age
3. Seems to cry more frequently than peers
4. Cries frequently

Self Esteem
1. You describe self in mostly positive terms
2. Little or no evidence of lowered self esteem
3. Describes self in some positive, some negative terms
4. Positive and negative terms, but mostly negative
5. Refers to self in derogatory terms, or avoids the question

Morbid thinking (death, violence)
1. None apparent
2. Some morbid thoughts - related to actual events
3. Somewhat more than usual morbid thoughts
5. Elaborate or extensive morbid thinking

Suicide and Suicide Ideation
1. None apparent
2. Has thought of suicide - usually when angry
3. Recurrent thoughts of suicide
4. Thinks about suicide and names methods
5. Has recently attempted suicide

Irritability (whining, chip on shoulder, hostility)
1. None
2. Normal amount
3. Occasional-slightly more than normal
4. Episodic - comes and goes
5. Frequent
6. Constant

Schoolwork
1. Performing at or above expected level
2. Not working to capacity or recent disinterest
3. Doing poorly in most subjects or major decline

Capacity to have fun
1. Interests & hobbies appropriate for age
2. Some interests but mostly passive, lacks enthusiasm
3. Easily bored, "Nothing to do"
4. No initiative, watches others or only TV. has to be coaxed to be involved in any activities.

Social Withdrawal
1. Enjoys good friendships with peers
2. Has several friends, not very close
3. Is passive in getting friends
4. Rejects opportunities for interaction
5. Does not relate to others

Expressive communication
1. Expresses self fairly well
2. Not very talkative, but will talk
3. Withdrawn, very reluctant to talk

Sleep
1. Occasional or no difficulty sleeping
2. Mild but frequent difficulty sleeping
3. Moderate difficulty sleeping almost every night
    a.. problem getting to sleep
    b. problem waking at night
    c. Problem waking in morning

Disturbance of eating
1. No problem
2. Mild____ Too little____ Too much____
3. Moderate____ Too little____ Too much____

Frequent Physical Complaints (head, stomach)
1. No complaints
2. Mild, occasional complaints
3. Frequent complaints,
4. Preoccupies with aches and pains

General Somatic
1. Normal
2. Occasional complaints of fatigue
3. Frequent complaints of being tired

Activity Level
1. Activity at usual level
2. Slight reduction of activity level
3. Activity greatly reduced from usual

Comments: