Integrative Counseling & Psychological Services, PC

Dr. Jane Houghtaling Walker, PhD • *Licensed Clinical Psychologist*

Naperville Location:
616 West 5th Avenue, Suite B • Naperville, IL 60563
630.717.7771 *(office)* • **630.206.2003** *(fax)*

Deerfield Location:
440 Lake Cook Road, Building 1 • Deerfield, IL 60015
847.892.6000 *(office)* • **847.892.6151** *(fax)*

630.418.0280 *(emergency)* • **integrativecps@gmail.com** *(email)*

(please print)

Confidential Child/Adolescent Client History

IDENTIFYING INFORMATION:

CLIENT NAME:______________________________ D.O.B.__________ SEX:___________

ADDRESS:______________________________ PHONE:______________________________

RELIGIOUS AFFILIATION: ______________________________

OTHERS IN HOUSE: ______ Parents ______ Friend ______ Children ______ Siblings ______ Others ______________________________

Referred By:______________________________

PERSON COMPLETING THIS FORM:

Name: ______________________________ Relationship to client: ______________________________

Check any of the following behaviors that have recently applied to the client:

______ Change in sleeping patterns
______ Agitation/ being upset
______ Change in eating patterns
______ Phobias/ fears/ anxiety
______ Withdrawal, isolation
______ Temper outbursts/ Aggression

______ Suicide attempt
______ Depression
______ Suicidal thoughts
______ Difficulty in concentration
______ Hurting self or others
______ Unstable moods

______ Alcohol and/or drug use
______ Psychological testing
______ Relationship difficulties
______ Other: ______________________________
____
____

HISTORY OF TREATMENT:

Has the client/family ever received counseling for emotional or substance abuse problems? __________ Yes __________ No

Explain if yes:______________________________

____

____

Problem treated for: ______________________________

Provider: ______________________________ When treated?______________________

Problem treated for: ______________________________

Provider: ______________________________ When treated?______________________

FAMILY HISTORY:

Father's name: ______________________________ Age: ________ Health: ______________________

Occupation: ______________________________ Home phone # ______________________________

Work phone # ______________________________ Cell phone # ______________________________

Mother's name: ______________________________ Age: ________ Health: ______________________

Occupation: ______________________________ Home phone # ______________________________

Work phone # ______________________________ Cell phone # ______________________________

(Step Parent(s) names, ages, health, occupation:) ______________________________

____

Name(s) and age(s) of brother(s): ______________________________

Name(s) and age(s) of sister(s): ______________________________

Any significant details about family members? ______________________________

Any family history of mental health treatment? ______________________________

Any significant individuals (other than family) in the home or client's background? ______________________________

____

Significant life events (include births, deaths, moves, traumatic events): ______________________________

____

PARENTAL MARITAL/PARTNER HISTORY: *(please give information pertaining to the parents.)*

Previously married? __________ If yes, please give name of ex-spouse and date(s) of previous marriage: ______________________

____

History of marital problems: ______________________________

____

Names, ages, significant information about children/stepchildren: ______________________________

____

DEVELOPMENTAL HISTORY:

Complications during pregnancy and/or delivery? _________ Yes ________ No

Clarify if yes: ____

____

Developmental milestones: (KEY: Mark "E" for Early; "A" for Age-appropriate; "D" for Delayed)

Sitting alone _______ Walking, crawling _____ Toilet training _____

Speaking words _____ Speaking sentences _____

MEDICAL HISTORY:

Are there concerns regarding medical treatment that the client is currently receiving or has recently received? _________ Yes _________ No

Explain if yes: ____

Please list ALL medications: ____

Please list any significant medical problems for other members of the family: ____

____

Has the client ever been physically or sexually abused? ________ Yes ______ No

Explain if yes: ____

EDUCATION:

Current school or last school attended: ____

Grade level: _________ Academic Functioning (grades): ____

Did the client ever receive special services in school? ____

Academic problems or special needs: ____

VOCATIONAL:

Present job: ____ Employer: ______________________________________

Length of time at present job: ________________ Work history: ____

____

LEGAL HISTORY:

Are there any legal charges pending? _________ Yes __________ No Has the client ever been arrested? _________ Yes _________ No

Specify: ____

____

Signature: ____ Date: ________________________