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Licensed Clinical Social Worker

Pioneer Peak Mental Health, Inc.
Advancing well-being – Strengthening lives

Client Information and History Form

Instructions: Please complete all sections. Write "same" if information is contained in, or the same as, previous sections.

Today's Date:

Client Name. Date of Birth: SEX ☐MALE ☐FEMALE

Social Security No.:

Mailing Address:

STREET OR PO BOX CITY/STATE/ZIP PHONE

Physical Address (if different):

STREET CITY/STATE/ZIP

	OK to leave a message?		Which is preferred number?
Home Phone:	Y	N	☐
Work Phone:	Y	N	☐
Cell Phone:	Y	N	☐

Highest Education completed:

Parents' Names: Parents' Date of Birth: Mother: Father

Mailing Address if different:

Physical Address if different:

Mother's employer and position: How Long?

Father's employer and position: How Long?

How did you hear about me?

To whom will bills be sent?

Address & telephone (if different than the client's):

Primary Care Physician: Phone:

Contact in case of emergency (name and phone): Relationship:

Responsible Party: Relationship:

Social Security No.: Date of Birth:

PO Box 873103
Wasilla, AK 99687-3103
(907) 775-8742

Child and Family Information

THIS FORM WAS COMPLETED BY: RELATIONSHIP TO CLIENT:

SCHOOL: GRADE: TEACHER:

ETHNIC BACKGROUND: IS CHILD ADOPTED: YES/NO
AGE AT ADOPTION:

THIS REFERRAL WAS INITIATED BY:

WHAT IS THE MAIN CONCERN ABOUT YOUR CHILD?

	PARENTS NAME	AGE	OCCUPATION	RACE	CONTACT W/CHILD
Mother					Y/N
Father					Y/N
Stepmother					Y/N
Stepfather					Y/N
Legal Guardian					Y/N

OTHER CHILDREN IN FAMILY

NAME	AGE	SEX	GRADE	STRENGTH OF RELATIONSHIP TO CHILD

OTHER PEOPLE IN THE HOUSEHOLD

NAME	AGE	SEX	EDUCATION	RELATIONSHIP TO CLIENT

EARLY DEVELOPMENT

PREGNANCY

Was there anything unusual during pregnancy?

Did you smoke, drink, or use drugs during pregnancy? YES/NO

What and How Much?

LABOR AND DELIVERY

Did anything unusual occur during labor or delivery?

Birth weight: Birth length:

Did your Child require special care as a newborn? YES/NO

Was your Child in the hospital, or re-admitted, in the first few months? YES/NO

Was your baby: ☐Predictable ☐Unpredictable ☐Easy ☐Difficult

DEVELOPMENTAL MILESTONE

Does your Child show a hand preference? R L

Sat unsupported at	months	Walked unsupported at	months
Bladder trained at	months	Dry bed after	years
Bowel trained at	years	First words at	months

Was there anything in the first three years that you thought might effect growth, development, or school success?

HEALTHCARE HISTORY

Physician/Pediatrician: Phone:

Has your child taken medication for a long period of time? YES/NO

If so, what? Why?

Is your child taking medication now? YES/NO If so, What?

Does your child regularly see a physician/therapist other than their pediatrician? YES/NO

If yes, Who?

PREVIOUS ILLNESS: (PLEASE CHECK ALL THAT APPLY)

Illness	Year	Illness	Year
☐Meningitis		☐Skull Fracture	
☐Encephalitis		☐Ingestion of Poison	
☐Recurrent Ear Aches		☐Reaction to Drugs	
☐Recurrent Respiratory Infections		☐Allergies (List):	
☐Episodes of Loss of Consciousness		☐Growth Problems	
☐Seizures		☐Tires too easily	
☐Concussion			
☐Hearing/Vision Problems			

FAMILY HISTORY

ANY FAMILY MEMBERS WITH THE FOLLOWING PROBLEMS?

(Family defined as brothers, sisters, parents, grandparents, aunts, and uncles).

Condition	Relation
Learning Problems	
Depression	
Alcoholism/Drug Addiction	
Epilepsy	
Mental Retardation	
Trouble with the law	
Hyperactivity	
Anxious or perfectionist	
Speech or hearing problems	
TIC behaviors or nervous habits	
Psychiatric hospitalization	
Other behavior or emotional problems	

SCHOOL HISTORY

IS YOUR CHILD CLASSIFIED AS?

☐Learning disabled
☐Speech/Language disordered
☐Severely emotionally disturbed
☐Other Health Impaired (for what condition):

SCHOOL INFORMATION

Is your child on an IEP in school? YES/NO

What special services does s/he receive?

What accommodations does s/he receive?

Has your child repeated any grades? YES/NO Which grade?

What grades did your child get last term?

Have your child's grades changed recently? YES/NO How?

How is your child's behavior in school?

Does your child have trouble paying attention in class? YES/NO

As a rule, does your child complete and turn in homework? YES/NO

Time your child spends on homework each day? (hours) Time you spend helping? (hours)

Comments about school:

BEHAVIORAL HISTORY

HAS YOUR CHILD EVER: (PLEASE CHECK ALL THAT APPLY)

☐Been physically abused

☐Been sexually abused

By whom: For how long/how many times:

Treated for

☐Arrested or adjudicated

For what: Result:

☐Run away from home

When: For how long:

☐Set a fire When:

☐Assaulted someone Who: What happened:

☐Destroyed property When: How:

☐Threatened to hurt self When: How:

☐Hurt self When: How:

☐Threatened to hurt someone else

When: Who: How:

☐Used a weapon When: What:

☐Used alcohol When: What:

☐Used drugs When: What:

☐Used tobacco When: How much:

☐Had grades in school drop a lot When:

☐Been sexually active

☐Gang member

☐Cruelty to animals

☐Had treatment for a psychological problem

When:

What for:

Where: ☐In hospital ☐Outpatient

Type of treatment: ☐Individual treatment ☐Family treatment

Medication YES/NO Name(s)

PLEASE CHECK ☑ ANY THAT CONCERN YOU ABOUT YOUR CHILD:

☐Disobedience

☐Nightmares

☐Memory problems

☐Difficulty sleeping

☐Low self esteem

☐Frequent crying

☐Disorganization

☐Gives up easily

☐Time spent on TV or computer games

☐Temper tantrums

☐Lying

☐Arguing

☐Verbal fighting

☐Whining

☐Clumsiness

☐Moodiness

☐Headaches

☐Lack of friends

☐Unacceptable friends

☐Stealing

☐Hitting

☐Sexual behavior

☐Alcohol use

☐Drug use

☐Tobacco use

☐Stomachache

DISCIPLINE

When does your child need to be disciplined?

What do you do?

How does your child respond?

FAMILY ACTIVITIES

What does your Child like to do?

What do you like to do with your Child?

What are your Child's strong points?

What does your family do together?

How often do you read to your Child?

How often does your Child read alone?

What are your Child's favorite books?

How much TV does your Child watch on a typical day?
On a typical weekend day?

Do you have a computer at home? YES/NO

Does your Child use it? YES/NO

What computer software do you have for your Child?

What are your Child's chores?

What problems are there in getting them done?

Does your Child have a best friend? YES/NO

Does your Child play with a group of Children in school? YES/NO

In your neighborhood? YES/NO

What problems does your Child have in getting along with friends?

What problems does your Child have in getting along with brothers and sisters?