

Date \_\_\_\_\_

**FAMILY AND MEDICAL HISTORY –Youth/ Family  
CHILD’S PRESENT FAMILY**

<u>Name</u>	<u>Date of Birth</u>	<u>Age</u>	<u>Occupation</u>
Parent/s or _____ Adults _____	_____	_____	_____
Involved: _____	_____	_____	_____

Do all legal guardians approve of therapy for the child? Yes \_\_\_\_\_ No \_\_\_\_\_

<u>Name</u>	<u>Date of Birth</u>	<u>Age</u>	<u>Grade/School Name</u>
Stepparents, _____ Or Co-parents _____ if applicable: _____	_____	_____	_____

<u>Name</u>	<u>Date of Birth</u>	<u>Age</u>	<u>Grade/School Name</u>
Minor Client/s _____	_____	_____	_____

Other Children _____ If Applicable: _____	_____	_____	_____
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ADDRESS: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

PHONE #s: Name: \_\_\_\_\_ # \_\_\_\_\_ Ok msg? \_\_\_\_\_

Name: \_\_\_\_\_ # \_\_\_\_\_ Ok msg? \_\_\_\_\_

Name: \_\_\_\_\_ # \_\_\_\_\_ Ok msg? \_\_\_\_\_

Email/s: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone# \_\_\_\_\_

**For parent/s, list dates (if applicable) of:**

Parent: \_\_\_\_\_ Marriage \_\_\_\_\_ Separation \_\_\_\_\_ Divorce/Widow \_\_\_\_\_ Remar/Dating \_\_\_\_\_

Parent: \_\_\_\_\_ Marriage \_\_\_\_\_ Separation \_\_\_\_\_ Divorce/Widow \_\_\_\_\_ Remar/Dating \_\_\_\_\_

**MEDICAL**

Please list any **medications** child is taking. \_\_\_\_\_ How long? \_\_\_\_\_ Reason? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date (approx.) of child’s last **physician’s** visit: \_\_\_\_\_

Please list any current or chronic **health or mental health** issues for child or family members: \_\_\_\_\_

\_\_\_\_\_  
Please list any other therapeutic or support **services involved** with child or family: \_\_\_\_\_

\_\_\_\_\_  
Please list **legal/physical custody** arrangements, and **parenting time structure**, for children involved, if applicable: \_\_\_\_\_