Date_____

FAMILY AND MEDICAL HISTORY –Youth/ Family

CHILD'S PRESENT FAMILY

Name **Date of Birth** **Age** **Occupation**

Parent/s or Adults Involved: _____ _____ ____ _____

_____ _____ ____ _____

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

Stepparents, Or Co-parents if applicable: _____ _____ ____ _____

_____ _____ ____ _____

Name **Date of Birth** **Age** **Grade/School Name**

Minor Client/s _____ _____ _____ ____ _____

Other Children/siblings If Applic: _____ _____ ____ _____

_____ _____ ____ _____

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:_____

_____

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

_____

_____

Does Child have an IEP at school? IF so, please describe:_____

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