REGION II HUMAN SERVICES

Client History Questionnaire Date:_____

(for parent to complete)

Child Information

Child's Name: _____

Date of Birth: _____ Age: _____ Grade: _____

Parent/Guardian Name(s): _____

Relationship to Child: _____

Phone: _____ Email: _____

Who has legal custody? _____

Emergency Contact: _____ Phone: _____

Reason for Visit

What concerns brought your child to counseling?

_____

What changes would you like to see for your child?

_____

Safety & Risk

☐ Thoughts or talk about suicide

☐ Self-harm behaviors

☐ Aggressive behavior toward others

☐ History of running away

☐ Current alcohol, vaping, or drug use

☐ Recent major loss or trauma

Behavioral Health History

Ever hospitalized for mental health concerns? ☐ Yes ☐ No

Previous counseling or psychiatric care? ☐ Yes ☐ No

Current or past diagnoses: _____

Psychiatric medications (current/past): _____

Medical History

Primary Care Provider: _____

Last PCP Visit: _____

Have they had their yearly well-check? ☐ Yes ☐ No

Are their immunizations up to date? ☐ Yes ☐ No

Last Dental Visit: _____

Significant medical conditions: _____

Current medications (or attach list): _____

Allergies: _____

Height: _____ Weight: _____

Development & Daily Living

Pregnancy/birth concerns? ☐ Yes ☐ No (If yes, explain): _____

Speech/language delays? ☐ Yes ☐ No

Learning concerns or IEP/504 Plan? ☐ Yes ☐ No

Difficulty with (check any): ☐ Sleeping ☐ Eating ☐ Toileting ☐ Dressing ☐ Daily routines

Family & Social Snapshot

Who lives in the home? _____

Primary language spoken: _____

Recent family changes (moves, separations, new siblings): _____

Who are your child's main supports? _____

School name & teacher: _____

Trauma & Legal

History of abuse, neglect, or major accidents: ☐ Yes ☐ No

CPS involvement: ☐ Yes ☐ No (Current ☐ Past ☐)

Legal issues or juvenile court involvement: ☐ Yes ☐ No

Strengths & Interests

Your child's strengths: _____

Activities/hobbies your child enjoys: _____

Symptom Snapshot

☐ Sadness or frequent crying

☐ Frequent worries or fears

☐ Trouble sitting still or paying attention

☐ Anger or tantrums that are hard to control

☐ Sleep problems

☐ Trouble getting along with peers or adults

☐ Problems at school (behavior, grades, attendance)

☐ Talk of harming self or others

Additional Information

Anything else you'd like us to know about your child or family:

_____
_____
_____
_____
_____