LAURA LADEFIAN
COUNSELING

CLIENT HISTORY FORM

Your child's name: _____ Date of Birth: _____

School: _____ Grade: _____

Parent(s) or Legal Guardian's Name: _____

Marital Status: S M D W Does anyone else share legal custody? Yes No

If yes, please name: _____

Home address: _____

Phone: _____ Email: _____
Do I have permission to leave a voicemail? Yes No

Referred by: _____

Emergency Contact: _____
Name Phone
I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so:_____
Parent/Guardian Date

Please briefly describe the reason you have initiated counseling for your child: _____
_____
_____
_____

What are your goals for therapy? _____
_____
_____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, illnesses, injuries, or surgeries your child has had: _____
_____

Primary Care Physician: _____ Date of last visit: _____

Current Medication(s):

Medication	Dosage	Purpose	Physician

Any significant family history of illness? _____
_____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please list approximate dates and reasons): _____
_____
_____

Prior Mental Health Diagnoses and/or Psychiatric Medications: _____
_____
_____

PSYCHOSOCIAL HISTORY:

Please list names, relationships, and ages of all individuals living in the home with the child: _____
_____
_____
_____

Significant Family History or Dynamics: _____
_____
_____

Significant Social History or Dynamics: _____
_____
_____

Significant Academic History or Dynamics: _____
_____
_____

Major Life Changes or Transitions (family changes, move, loss, etc): _____
_____
_____

Strengths, Hobbies, Interests & Activities: _____
_____
_____

Has your child ever experienced any traumas? (Abuse, neglect, witness to domestic violence, victim of violent crime): _____
_____
_____

If yes, has there been any DFCS or legal system involvement? _____
_____
_____

CURRENT SYMPTOMS: (Circle all that apply)

Anxiety	Tantrums	Mood Swings	Depression
Anger	Cries Easily	Nausea	Panic Attacks
Self-Harm	Irritability	Excessive Worry	Wetting the Bed
Headaches	Peer Difficulties	Startles Easily	Defiant Behavior
Fatigue	Nightmares	Racing Thoughts	Hyperactivity
Impulsivity	Learning Disability	Loss of Interest	Change in Eating
Change in Academics	Long Periods of Sadness	Change in Toileting Habits	Difficulty Concentrating
Sibling Rivalry	Separation Anxiety	Substance Abuse	Change in Sleep
Intrusive Memories	Developmental Delay	Memory Challenges	Physical Aggression

Other: _____

Any additional information you would like to include: _____
_____
_____

I hereby certify that the content disclosed within these pages is accurate and complete to the best of my knowledge.

_____ _____
Parent/Guardian Signature Date