Journeys End Counseling
Patient History Questionnaire
Child/Family Therapy

Date: _____

Child's name: _____ DOB:____/___/____ Sex: ☐ Female ☐ Male

Insurance ID: _____ Social Security Number:_____:

Parent/guardian name: _____

Address:_____

City: _____

Cell: _____ Home:_____

Email: _____

Contact Preference: Phone/Cell/Email (please circle preference)

Family composition:

_____

_____

_____

Please list recent changes to your household/family _____
_____

_____

_____

_____

Please list any medical concerns/health issues for you or children (as appropriate) please include family history.

_____

_____

_____

_____

Child's name: _____

How does your child respond to verbal praise, hugs, kisses and other displays of affection?

_____

_____

_____

Does your child comfortably communicate his/her needs to you?

History of self-injurious or aggressive behaviors: ☐ Y ☐ N, if yes, date of most recent attempt

_____/_____/_____

_____

_____

_____

History of violence or aggression toward self or others ? ☐ Y ☐ N , if yes,

_____

_____

_____

_____

History of sexual or physical abuse? ☐ Y ☐ N, if yes, is the child experiencing nightmares, or other post trauma responses?

_____

_____

_____

Does the child have a history of substance exposure at birth? ☐ Y ☐ N , if yes please describe any current affects in behavior, mood regulation that you have observed.

_____

_____

_____

Prior hospitalizations or psychiatric treatment or counseling: ☐ Y ☐ N if yes, most recent hospitalization or treatment episode

_____

_____

Child's name: _____

Legal History: ☐ Y ☐ N

_____

_____

_____

Educational history:

Child's previous school and/or educational placement:_____

_____

Does your child have an Individual Educational Plan (IEP) ? ☐ Yes ☐ No

_____

_____

Does your child have a history of academic difficulties or disruptive behavior? ☐ Yes ☐ No

_____

_____

_____

Do you have any academic concerns for your child? ☐ Yes ☐ No

_____

_____

_____

Child's current school/grade:

_____

_____

Please list all medications or vitamin supplements you are currently taking and frequency:

_____

_____

_____

_____

Child's name: _____

Loss or grief:

_____

_____

Include brief description/observations of child's adjustment to being placed in your home:

Recent changes in school, housing, friendships? ☐ Yes ☐ No

_____

_____

_____

Are there other children in your home? ☐ Yes ☐ No

_____

_____

_____

Are there pets in your home? ☐ Yes ☐ No

How does your child interact with the pets?

_____

_____

Recreational or social activities:

_____

_____

_____

Does your child ask to attend church? ☐ Y ☐ N

How does faith and spirituality impact your life? ☐ Greatly ☐ Somewhat ☐ Not at all

Do you attend or belong to a church or worship center? ☐ Y ☐ N

How often do you attend: ☐ Weekly ☐ Monthly ☐ Occasionally?

Child's name: _____

Desired goal(s) for counseling

_____

_____

_____

_____

If you have had counseling in the past please list what types of activities or assignments were successful in helping to resolve the problem or concern.

_____

_____

_____

Are there any other concerns or information that you would like to share that has not been addressed?

_____

_____

_____

Thank you for completing this information it will help us to best meet the therapeutic needs of your child and your family.

How did you hear about us? ☐ Phone Book ☐ Insurance ☐ Referral from friend ☐ Referral from church ☐ Community referral ☐ website ☐ other

_____ _____

Parent/Guardian/Patient Date

_____ _____

Therapist Date

**Please feel free to provide other supporting documentation such as, psychological evaluations, educational assessments or behavior reports.