THE FAMILY GUIDANCE CENTER
of Southern California

# FAMILY HISTORY FORM

Please complete and return. If you would like to provide additional information, please use the back of the form. Please submit any educational, neurological, or psychological records that you feel would benefit the therapist in learning about your family.

## General Information

| | | |
|---|---|---|
| Family Last Name(s): | Date: | Name of Person filling out form: |
| Family members first names: | Family members ages: | Preferred Contact phone #: |
| Primary insured individual's name: | Social Security #: | Primary insured individual's DOB: |
| Address: | Email Address: | Emergency Contact Name/Phone: |
| Family's ethnicities: | Family's preferred language: | Family's religion (if applicable): |

**Seeking the following Services:**

___ Relationship Development Intervention (RDI) ____Family Therapy

___Individual Therapy ____Behavioral Therapy ___Educational Consultation

__ Parent Training ___ Group Therapy ___ Other: Please specify

**Primary reason(s) for seeking services:**

___Autism Spectrum ____Social Issues ____Development Delays

___ Anger Management ____Parenting Issues ____Anxiety

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___Coping ____Depression ____ Eating disorder

___Fear/phobias ____Sexual concerns ____ Sleeping problems

___Compulsive behaviors ____Alcohol/drugs ____Hyperactivity

___ Other mental health concerns (specify):

-

_____

_____

Please answer the following questions to the best of your ability:

1. **Goals**: What are your goals for coming here? Please be as specific as possible.

2. **Opinions:** Is there any difference of opinion among different family members over whether problems exist, or what needs to be done? If so, please give us each person's viewpoint of the problems and solutions.

3. **Living Arrangements:** Who currently lives in your home?

4. **Child Expectations**: Does the child/children know why they are coming to therapy? If so, what do they know and expect?

5. **Marriage**: Please tell us about parents' marital status. Is this the first marriage for both? If there were prior marriages, are there any children from them? Are parents divorced? Remarried? Separated? If divorced, tell us your opinion of the impact of the divorce on the child. Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling?

6. **Parent 1:**

____ Natural parent ____ Step-parent ____Adoptive parent ___Foster home ____ Other (specify):

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Please tell us about your occupation.

Are you currently working? _____ Part time/Full time? _____

Where employed: _____Work phone: _____
_____

Parent 1's education: _____
_____

Is there anything notable, unusual or stressful about the child's relationship with the mother?
____ Yes __ No If Yes, please explain: ____
__
_____
_____

How is the child disciplined by parent 1? _____
_____

For what reasons is the child disciplined by the parent 1? _____
_____

**7. Parent 2:**

____ Natural parent ____ Step-parent ____Adoptive parent ___Foster home ____ Other (specify):

Please tell us about your occupation.

Are you currently working? _____ Part time/Full time? _____

Where employed: _____Work phone: _____
_____

Parent 2's education: _____
_____

Is there anything notable, unusual or stressful about the child's relationship with the parent 2?
____ Yes __ No If Yes, please explain: ____
__
_____
_____

How is the child disciplined by the parent 2? _____
_____

For what reasons is the child disciplined by the parent 2? _____
_____

**8. Adoption**: If your child was adopted, at what age was the adoption? What information do you have about the history of the biological parents and the child's history before the adoption?

**9. Siblings**: Tell us any important information about siblings that would help us.

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**10. Family Health:**

Have any of the following diseases occurred among your family's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

| | | |
|---|---|---|
| ___ Allergies | _____Muscular Dystrophy | _____Deafness |
| ___ Anemia | _____Diabetes | _____Nervousness |
| ___ Perceptual motor disorder | _____Glandular problems | _____Asthma |
| _____ Bleeding tendency | _____Heart diseases | _____Mental Retardation |
| ___ Blindness | _____High blood pressure | _____Seizures |
| ___ Cancer | _____Kidney disease | _____Spinal Bifida |
| ___ Cerebral Palsy | _____Mental illness | _____Suicide |
| ___ Cleft lips | _____Migraines | _____Other (specify): |
| ___ Cleft palate | _____Multiple sclerosis | |

Comments re: Family Health: _____

_____
_____
_____
_____
_____
_____
_____

**11. Stress**: Please tell us about any recent stresses and crises that have occurred in the family in the last few years. For any stress you list, tell us how you think it may have affected your family. (Ie. parent who must work unusually long hours, divorce, moving, death) Also, include any anticipated future stresses.

**12. Medical History**: Please share anything notable/significant about your family's medical status, including neurological problems and allergies and note which family member was affected.

| | | |
|---|---|---|
| ___ Abortion | ____Hay fever | _____Pneumonia |
| ___ Asthma | ____Heart trouble | _____Polio |
| ____ Blackouts | ____Hepatitis | _____Pregnancy |
| ___ Bronchitis | ____Hearing | ____Speech |
| ___Hives | ____Rheumatic Fever | ____Sensory/Motor |
| ____ Cerebral Palsy | ____Influenza | _____Scarlet Fever |

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| | | |
|---|---|---|
| ___ Chicken Pox | ____Lead poisoning | _____Seizures |
| _____ Congenital problems | ____Measles | _____Severe colds |
| ___ Croup | ____Meningitis | _____Meningitis |
| ___ Diabetes | ____Miscarriage | _____Headaches |
| ___Sexually transmitted disease | ____Multiple sclerosis | _____Thyroid disorders |
| _____ Dizziness | ____Mumps | _____Vision problems |
| _____ Ear aches | ____Muscular Dystrophy | _____Wearing glasses |
| _____ Ear infections | ____Nose bleeds | _____Whooping cough |
| _____ Eczema | ____Other skin rashes | _____Other |
| ___ Encephalitis | ____Paralysis | _____Fevers |

List any current health concerns: _____
_____
_____
_____

List any recent health or physical changes: _____
_____
_____
_____

Do any of your family members take medications? If so, please note who and what medication they are taking: _____
_____
_____
_____
_____
_____
_____
_____

**13. Children's Education:**

**Child 1 Name:** _____
Current school: _____
Type of school: ____ Public ____ Private ___ Home schooled _____ Other (specify): ___
_____
Grade: _____

**Child 2 Name:** _____
Current school: _____
Type of school: ____ Public ____ Private ___ Home schooled _____ Other (specify): ___
_____
Grade: _____

**Child 3 Name:** _____
Current school: _____
Type of school: ____ Public ____ Private ___ Home schooled _____ Other (specify): ___
_____

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Grade: _____

**14. Parenting:**

Who handles responsibility for your child(ren) in the following areas?

School: ____Parent 1 ___ Parent 2 ___ Shared ____ Other (specify): ___

Health: ____Parent 1 ___ Parent 2 ___ Shared ____ Other (specify): ___

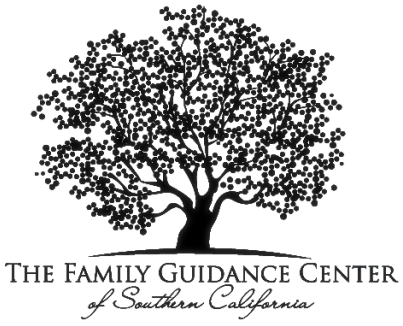
Problem behavior: ____Parent 1 ___ Parent 2 ___ Shared ____ Other (specify): ___

**15. Counseling/Prior Treatment History:** Please share with us any prior about any prior counseling any member of the family has received. What worked? What did not work?

**16. Leisure/Strengths:**

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.) What are the family's favorite activities? What does the child/adolescent do with unstructured time? What would you consider your child's strengths to be? What do the parents enjoy doing?

Any additional information that you believe would assist us in understanding your family?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