

**Macomb Family Services, Inc.
Age 17 & Under-Client Self-Report**

Date: _____ Case No: _____

Client Name: _____ Client Social Security #: _____

Date of Birth: _____ Age: _____

Form completed by _____ Relationship to Child: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home) _____ (Work) _____

May the agency/therapist contact you at home? Yes ___ No ___ Work? Yes ___ No ___

Why are you seeking counseling today? (Please describe the problems as best you can).

How long have these problems/symptoms been present?

What things have you tried to do in response to your child's problems?

Are there any situations at home or school that you think may be affecting your child?

What improvements do you want?

Personal: _____

Family: _____

Social: _____

School: _____

Family Information

What is the child's family situation? What is the marital status of his or her parents?

Married Divorced Divorcing Separated Never Married

Are there special considerations for the child in the home? For example, are grandparents or other family members raising the child; or is the child a member of a foster family/home?

Please list all family members

	Name	Age	Deceased		Living with you	
			Yes	No	Yes	No
Mother						
Father						
Spouse						
Children						

Please list any others currently living in the home.

Name	Age	Relationship to you

Who is the custodial parent?

What are the visitation arrangements?

Does he or she share a room? Yes No Does he or she share a bed? Yes No

How would you describe your current relationship with the child? Good Fair Poor N/A

Does the child have any conflicts with family members? Yes No If yes, please explain:

For purposes of funding and setting the service fees, kindly complete the following.

Family Member	Employer	Annual Income
Father		\$
Mother		\$
Other Sources of Income		\$
Total Household Income		\$

How many different homes has your child lived in since birth?

Dates	City/State	Reason for moving

Counseling and Prior Treatment

Please list all previous treatment experiences.

Type of Treatment	Yes	No	Date (s)	# Of times	Where	Outcomes
Counseling/Psychiatric Treatment						
Alcohol/Drug Treatment						
Hospitalizations						
Self-help groups: AA, Al-Anon, ACOA, Overeaters, Other(s) _____						

Has he or she expressed suicidal thoughts? Yes No Current Past
 If yes, please describe; and if they are current, please provide some details.

Has the child ever attempted suicide? Yes No
 If yes, list how many times, the most recent date, and the method (s) used.

Has the child ever experienced homicidal thoughts? Yes No Current Past
 If yes, please describe; and if they are current, please provide some details.

Has he or she ever acted on these thoughts? Yes No
 If yes, list how many times, the most recent date, and the method (s) used.

Has the child ever assaulted anyone? Yes No
 If yes, list how many times, and include the dates and how the assault(s) happened.

Has anyone in the family been diagnosed with a mental illness? Yes No

Name & relationship to child	Type of illness	Date Identified

Has anyone in the family, or a close friend ever attempted or committed suicide? Yes No

Name & Relationship to child	Attempted or Committed?	Date (month & year)

Has your child ever experienced any of the following?

Current Past No

- Severe childhood illnesses
- Death in the family
- Severe injury
- Problems in school
- Physical Abuse
- Emotional Abuse

Current Past No

- Sexual Abuse
- Trauma from crime
- Emotional difficulty due to divorce
- Sibling conflicts
- Parenting problems
- Physical / Domestic violence

Please check the following symptoms as they apply.

Symptom	Daily	Weekly	Monthly
Overall depression			
Can't concentrate			
Tired/Exhausted			
Poor attention span			
Easily Distracted			
Feeling Helpless			
Restless, fidgety			
Irritable			
Talks excessively			
Destroys property			
Initiates fights			
Temper tantrums			

Symptom	Daily	Weekly	Monthly
Excessive worrier			
Easily angered			
Isolates			
Alcohol/drug use			
Defies authority			
Trembling or Shaky			
Pulls out own hair			
Sleep disturbance			
Complains of anxiety			
Eats non-food items			
Eats, then vomits			
Binge Eating			

Physical, Medical, & Psychological History

- How old was the mother when the child was born? _____ Length of pregnancy _____
- Was the child planned? Yes No
- Was the child adopted? Yes No
- Were there any problems during pregnancy and/or infancy (up to 1 year of age)? Yes No
If yes please explain _____
- What was his/her birth weight? _____ How long was the labor? _____
- What type of delivery was it? Natural Caesarian Breech Forceps

Please check yes or no & answer the following physical, medical, & psychological questions.		Yes	No
At Birth & Infancy			
1	Did the infant have any breathing problems? If yes, Please explain:		
2	Was oxygen needed?		
3	Was an incubator used? If yes how long?		
4	Was a blood transfusion required?		
5	Medications?		
6	Did your child have yellow jaundice?		
7	Was the child breast-fed? (If yes, for how long?		
8	Was he or she colicky?		
9	Were there sleep problems?		
10	Was the child alert?		
Childhood & Adolescence			
11	Was he or she markedly hyperactive?		
12	Did he or she display temper tantrums?		
13	Did your child crawl, stand, and walk at an appropriate age?		
14	Did your child color, write, and tie his or her shoes at an appropriate age?		
15	Was speech developed at an appropriate age?		
16	Are his or her immunizations up to date?		
17	Does he/she have recurring physical symptoms or pain? If yes, Please describe:		
18	Does he/she have a physical limitation or disability? If yes, Please explain:		
19	Has your child ever been hospitalized? If yes, Please explain:		
20	Has your child ever had any seizures? If yes Please explain:		
21	Were or are there any other developmental problems in infancy/childhood? If yes, please explain:		
22	Is he or she on a special diet? If yes Please explain:		
23	Does your child eat less than 3 meals per day? If yes Please explain:		
24	Do you have any concerns regarding your child's eating patterns? If yes Please describe:		
25	Has your child's weight changed by more than 10 pounds in the past year? If Yes, please explain:		
26	Has alcohol or drug use ever caused problems in his/her life? If yes Please explain:		
27	Has he or she ever taken more medication than the doctor prescribed? If yes please explain:		
28	Has your child ever been told he/she has a drinking or drug problem? If yes please explain:		

Please list current medical conditions below.	Medications Prescribed		Name of Medication	Date Prescribed	Dosage	Physician
	Yes	No				

Are there any other developmental or medical/physical issues that need to be addressed? Yes No
 If yes, please describe: _____

Please list any family history of medical problems. _____

Is your child allergic to any medications, drugs, or other substances? Yes No

If yes, please describe: _____

Does your child take any over the counter medications? Yes No

If yes, please list: _____

Educational History

Did your child attend a pre-school or day-care program? Yes No

When? _____ How long did he or she attend? _____

Where does your child attend school? _____

Teacher's Name _____

Grade _____ Current grade average (A-F) _____ Any recent changes? _____ Up Down

Were any grades repeated? Yes No If Yes, what grade (s)? _____

Has your child ever had special tutoring? Yes No Type: _____

Has your child ever attended special education classes? Yes No Type: _____

How would you rate your child's relationship to his/her teacher(s)? Excellent Good Fair Poor

Has your child ever been suspended/expelled from school? Yes No

When? _____ For how long? _____

How many different schools has your child attended? _____

How would you rate your child's behavior in school? Excellent Good Fair Poor

Chemical & Substance Use History

Has your child's social activities included the use of drugs or alcohol? Yes No

If yes, explain: _____

Do you suspect a drug/alcohol problem? Yes No

What is the drug of choice? _____ When was a substance last used? _____

How much is, or was being used? _____ Longest period of abstinence? _____

Please complete the following table as it relates to your child.

Child's Current Age _____	Age of first use	Age of last use	Method of use				Amount	How Often?	Used in last 48 hours		Used in the last 30 days	
			Oral	Injection	Smoke	Inhale			Yes	No	Yes	No
Caffeine												
Nicotine												
Alcohol												
Barbiturates												
Valium / Librium												
Cocaine/Crack												
Heroin/Opiates												
Marijuana												
PCP												
LSD												
Mescaline												
Inhalants												
Ecstasy												
Crank/Ice												
Other												

Please check all that may apply to your child.

- | | |
|---|---|
| <input type="checkbox"/> Drinking/drug use before school | <input type="checkbox"/> Skipping class to get high |
| <input type="checkbox"/> Family/friends concerned about use | <input type="checkbox"/> Using during school hours |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Binge use |
| <input type="checkbox"/> Found evidence of alcohol/drug use at home | <input type="checkbox"/> Behavior changes |

Do any of your family members have a drug or alcohol problem? Yes No

If so, whom? _____

Have any of these people lived with or currently live with your child? Yes No

How has their substance use affected your child? _____

Would you like more information regarding the prevention of alcohol & drug use/abuse? Yes No

Leisure & Recreation

Has your child's activity level changed in the last 6 months? Yes No If yes, please explain:

How does your family have fun together? _____

What are your child's interests and play activities? What activities & interests does your child participate in (for example: sports, games, computers, scouts, etc.)? Are there any special talents or skills?

Does your child currently work? Yes No

Where? _____ How many hours per week? _____

Social

Describe how your child relates to other people (e.g., easily, shy, leader, follower, outgoing):

Who are the three people your child feels closest to? _____

Does your child ever isolate him/herself from others?

Cultural & Ethnic Information

What is the child's ethnic background (nationality)? _____

Does he or she identify closely with that background? Yes No

If yes, please explain: _____

Are there cultural, ethnic, or racial issues that may affect your child's therapy? Yes No

If yes, please explain: _____

LEGAL

Has your child ever been in trouble with the police/courts? Yes No

If yes, explain: _____

Is your child presently involved with the courts or on probation? Yes No

Charges	Date	Where (city)	Result

Spiritual & Religious

Does your family participate in a formal religion? Yes No

If yes, which religion: _____

Does your child participate in a formal religion? Yes No

If yes, which religion: _____

Are there any spiritual/religious issues that may affect his or her treatment? Yes No

If yes, explain: _____

Nutritional Patterns

Height: _____ Weight: _____ Is your child on a special Diet? Yes No

If yes, what kind? _____ Why? _____

How does your child get his/her exercise?

Does your child consume beverages containing caffeine? Yes No

If yes, what kind and how much per day, week, etc.? _____

Does he or she eat less than 3 meals per day? Yes No Does your child binge eat? Yes No

If yes, please explain: _____

Does your child eat and then purge (vomit)? Yes No

If yes, please explain: _____

Other Information

Is there anything else that you feel is important for your child's therapist to know about? If yes, please comment in the space provided and on the back if you need more room, thank you.

This form was completed by: _____ Date _____

Therapist Signature/Credentials Date _____