Family & Youth Institute, LLC

. . . Offering creative solutions for today's challenges.

Phone: 1-281-748-0233
Fax: 281-715-4742

E-mail: familyyouth1@hushmail.com
Web: www.familyandyouthinstitute.com

25511 Budde Rd., Suite 401-402
Marimed Building
Spring/The Woodlands, TX 77380

**CLIENT NAME:**_____ **DOB:** _____
**FIRST APPT. DATE:** _____**TIME:**_____
THERAPIST NAME:_____ THERAPIST SIGNATURE:_____

## BIOPSYCHOSOCIAL HISTORY

How did you learn about me and/or Family and Institute?_____

**CLIENT PRESENTING PROBLEM[S]: Why did you seek a counselor?**

_____
_____
_____
_____

**FAMILY HISTORY**

**Please list names of all who live in your home and their ages.**

**NAME** **AGE**
**NAME** **AGE**
**NAME** **AGE**
**NAME** **AGE**

**List names and ages of family members living elsewhere and reason for moving out.**

**NAME** **AGE**_____**REASON FOR MOVING**_____
**NAME** **AGE**_____**REASON FOR MOVING**_____
**NAME** **AGE**_____**REASON FOR MOVING**_____

**Has there been a Family divorce? If so, when? If applicable, what are the custody Issues?**

**DIVORCE?** **WHO** **DATE** **CUSTODY ISSUES?** _____
**DIVORCE?** **WHO** **DATE** **CUSTODY ISSUES?**_____

**Are there Family members outside the home actively involved in your family life? Is so who? How?**

**NAME** **INVOLVED HOW**_____
**NAME** **INVOLVED HOW** _____

**FAMILY SUBSTANCE USE** (check) **____TOBACCO** **____ALCOHOL** **____ ILLEGAL DRUG**
**____ PRESCRIPTION DRUG** **____VAPING**

____ never used
____ experimented
_ ___currently using tobacco/vaping for _____months/years.

**FAMILY MENTAL HEALTH HISTORY**

____ ____ Has any FAMILY MEMBER had prior out-patient treatment or been diagnosed for emotional/psychiatric problems?
What?_____
____ ____ Has any FAMILY MEMBER had prior in-patient treatment for a psychiatric or emotional disorder?
Location _____
Date(s)_____

**FAMILY MEDICAL HISTORY**

Family current medical concerns: _____
_____
_____
Family History of Allergies _____
Family History of Dementia _____

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**CLIENT HISTORY AND CONCERNS:**

**CLIENT RELEVANT CULTURAL CONSIDERATONS** (check all that apply for client)

| | | | |
|---|---|---|---|
| [ ] Death in family | [ ] Parenting concerns | [ ] Retirement | [ ] Child leaving home |
| [ ] Death of friend | [ ] Child behavior | [ ] Family fighting | [ ] Job change:New/Position Change/Quit/Laid o |
| [ ] Family illness | [ ] Domestic abuse, verbal | [ ] Marital Problems | [ ] Change in daily responsibilities |
| [ ] Personal illness | [ ] Domestic abuse, physical | [ ] Divorce/Separation | [ ] Change in financial status, increase/decrease |
| [ ] Friend illness | [ ] Political climate stressors | [ ] Conflict with In-laws | [ ] Outstanding personal achievements |
| [ ] Failure | [ ] School Problems | [ ] Threats/Violence | [ ] Weight/diet/food issues |
| [ ] Gambling | | | |

] Outstanding personal achievements
Other:_____

**CLIENT SPIRITUAL VALUE CONSIDERATIONS**. Please list any spiritual value variables that may be impacting your life. These may relate to you or other family members' spiritual values impacting you.----------
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**CLIENT EMOTIONAL/BEHAVIORAL PROBLEMS** (check all that apply for client)

| | | | | |
|---|---|---|---|---|
| [ ] drug use abuse | [ ] alcohol use, abuse | [ ] oppositional/defiant | [ ] repeats words of others | [ ] anxious/worry |
| [ ] assaults others | [ ] chronic lying | [ ] not trustworthy | [ ] hostile/angry mood | [ ] panic attacks |
| [ ] fire-setting | [ ] animal cruelty | [ ] bizarre behavior | [ ] frequently tearful | [ ] obsessions |
| [ ] stealing | [ ] violent temper, anger | [ ] indecisive, not assertive | [ ] hyperactive, ADHD | [ ] compulsions |
| [ ] immature | [ ] self-injurious threats | [ ] lack of attachment | [ ] frequent daydreams | [ ] suicide thoughts |
| [ ] distrustful | [ ] extreme worrier | [ ] breaks things | [ ] self-injurious acts | [ ] suicide attempts |
| [ ] impulsive | [ ] easily distracted | [ ] poor concentration | [ ] often sad, depressed | [ ] learning issues |
| [ ] poor appetite | [ ] poor sleep | [ ] codependence | [ ] abusive of others | [ ] delusions |
| [ ] disobedient | [ ] nervous breakdown | [ ] schizophrenia/psychosis | [ ] eating disorder | [ ] crying |
| [ ] dependent | [ ] guilt feelings | [ ] inferiority feelings | [ ] loneliness/isolates | [ ] mood swings |
| [ ] motivation | [ ] laziness/lethargic | [ ] memory problems | [ ] overly sensitive | [ ] low self-esteem |
| [ ] shy/withdrawn | [ ] emptiness | [ ] poor self-care/neglect | [ ] self-centeredness | [ ] perfectionism |
| [ ] suspicious | [ ] disorganized thought | [ ] abused by others | [ ] depression/low mood | [ ] meltdowns/rage |
| [ ] affectionate | [ ] cruel to animals | [ ] affectionate | [ ] argues, talks back | [ ] complains |
| [ ] friendly/social | [ ] disrupts family events | [ ] procrastinates/wastes time | [ ] hypochondriac/complain | [ ] fearful |
| [ ] interrupts | [ ] mute/refuses to speak | [ ] nightmares | [ ] prejudiced/intolerant | [ ] responsible |
| [ ] stubborn | [ ] bullied/victimized | [ ] rocking/repetitive moves | [ ] poor relationships | [ ] runs away |
| [ ] negative | [ ] truant/misses work | [ ] tics/hair chewing/other | [ ] not completing school | [ ] uncooperative |

**CLIENT EMOTIONAL/PSYCHIATRIC HISTORY**

**No Yes**

____ ____ Prior CLIENT outpatient psychiatric therapy or counseling _____
____ ____ CLIENT Prior in-patient treatment for a psychiatric or emotional disorder?
Location _____
Date(s)_____
____ ____Mental health medications taken?
List all medications and dosage taken for mental health._____
_____
____ ____Taking other over-the-counter medications? [ ] Yes [ ] No
List all over-the-counter meications_____
_____

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**Have you THE CLIENT had any psychological testing? When? Who? Where? What were the results** (Attach a copy of the report if available.)
**Test Name Test Date Who Tested Where?**
**Results?**

**FOSTER CARE/CPS/ADOPTION HISTORY** (check all that apply for client) [ ] FOSTER CARE [ ] CPS [ ] ADOPTION
[ ] never in foster care or CPS custody
[ ] investigation/involvement by CPS When?/Outcome? _____
[ ] currently in foster/CPS custody for _____ months/years
[ ] other pertinent information: _____
Summarize impact foster care had on yours or the client's life:_____

**Parents' current marital status: [ ] Married [ ] Divorced [ ] Widowed [ ] Single [ ] Cohabitating**
[ ] married to each other for _____ year(s) [ ] cohabitating for _____ year(s)
[ ] separated for _____ year(s) [ ] divorced for _____ year(s)
[ ] mother never married [ ] other info on parent(s) _____

**Adult Client's current marital status: [ ] Married [ ] Divorced [ ] Widowed [ ] Single [ ] Cohabitating**
[ ] married to each other for _____ year(s) [ ] cohabitating for _____ year(s[ ] separated for _____ year(s)
[ ] divorced for _____ year(s)
[ ] never married [ ] other information _____
[ ] married to original spouse

**Assess client's current living situation, including relationship with parents, relatives and siblings** _____

**CLIENT SUBSTANCE USE** HISTORY (check all that apply) **[ ] TOBACCO [ ] ALCOHOL [ ] ILLEGAL DR8G [ ] PRESCRIPTION DRUG [ ] VAPING**
[ ] never used drugs/alcohol/tobacco
[ ] experimented with drugs/alcohol/tobacco
[ ] currently using drugs/alcohol for _____ months/years.
[] currently using tobacco for _____months/years.

| TYPE | FREQUENCY | AMOUNT | DRUG OF CHOICE |
|---|---|---|---|

**Family alcohol/drug/tobacco abuse history**:_____

**CLIENT MEDICAL HISTORY** (check all that apply for client)
Describe current physical health: _____ Good _____Fair _____Poor
Medical problems/conditions
_____
Current Medications _____
Previous Medications _____
Allergies _____
Hospitalizations_____
Accidents_____

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**Describe any serious hospitalizations or accidents:**
Date _____ Age _____ Reason _____
Date _____ Age _____ Reason _____

**Client Medical history considerations** (Please check all that apply.)

| | | | |
|---|---|---|---|
| [ ] heart problems | [ ] head injury | [ ] digestive problems | [ ] surgeries |
| [ ] back/neck pain | [ ] hypothyroidism | [ ] hyperthyroidism | [ ] tics |
| [ ] high blood pressure | [ ] stomach aches | [ ] diabetes, type I | [ ] diabetes, type II |
| [ ] unexplained pains | [ ] PMS syndrome | [ ] cancer | [ ] overweight |
| [ ] underweight | [ ] muscle tension | [ ] headache | [ ] other |

**If you checked any boxes above, please explain.**

_____
_____
_____
_____
_____
_____

**Client DEVELOPMENTAL HISTORY** (check all that apply for client)
**Delayed developmental milestones** (**check only** those milestones **that did not** occur at expected age):

| | | |
|---|---|---|
| [ ] sitting | [ ] controlling bowels | [ ] ALL WITHIN NORMAL LIMITS |
| [ ] rolling over | [ ] sleeping alone | |
| [ ] standing | [ ] dressing self | |
| [ ] walking | [ ] engaging peers | |
| [ ] feeding self | [ ] tolerating separation | |
| [ ] speaking sentences | [ ] riding tricycle | |
| [ ] controlling bladder | [ ] riding bicycle | |
| [ ] speaking words | [ ] playing cooperatively | |

**CLIENT SOCIAL/ECONOMIC/LEGAL/SEXUAL HISTORY** (check all that apply to client)

| **Family financial situation:** | **Social support system for client:** | **Legal history for client:** |
|---|---|---|
| [ ] no current financial problems | [ ] supportive network | [ ] no legal problems |
| [ ] large indebtedness | [ ] few friends | [ ] now on parole/probation |
| [ ] poverty or below-poverty income | [ ] friends are substance users/abusers | [ ] arrest(s) not substance-related |
| [ ] impulsive spending | [ ] no friends | [ ] arrest(s) substance-related |
| [ ] financial situation unknown | [ ] distant from family of origin | [ ] court ordered this treatment |

[ ] jail/prison ____ time(s) total timE served: _____ other information_____

**Sexual history for client:**
[ ] sexually active
[ ] abstinent
[ ] unknown
[ ] inappropriate sex play/sexual acting out
[ ] other _____

**Social interaction for client:**

| | |
|---|---|
| [ ] normal social interaction | [ ] very shy |
| [ ] isolates self | [ ] dominates others |
| [ ] associates with acting-out peers | [ ] bullied |
| [ ] bullied by others | [ ] alienates self/others |

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**CLIENT EDUCATIONAL HISTORY:**
[ ] Regular Classes [ ] Gifted & Talented [ ] Special Education: Behavioral or Developmental
[ ] High School Grad. [ ] Post High School
Current or highest education level: _____
Degree: _____
Educational Related Concerns:
_____
_____

**CLIENT LEGAL HISTORY: [ ]YES [ ]NO IF SO, PARENT [ ] OR [ ]CLIENT OR [ ] OTHER**
What was the legal involvement?: _____
Concerns/Stressors related to legal involvement_____
_____
Acting out behaviors at school or work due to legal involvement
experience_____
_____

**CLIENT MILITARY HISTORY: [ ]YES [ ]NO IF SO, PARENT [ ] OR [ ]CLIENT**
Branch of Service_____ [ ] Active Duty [ ] Retired [ ] Discharged [ ] Reserves
Current or highest rank attained: _____
Combat Experience: _____
Concerns/Stressors related to service: _____

**CLIENT CURRENT OCCUPATIONAL/SCHOOL INFORMATION: [ ]WORK [ ] CLIENT [ ] OTHER**
Currently Employed/School _____ [ ] Retired [ ] Self Employed [ ] Unemployed
[ ] Work at Home
Current or highest education level: _____
Work/School Performance:
Comments:_____
Work/School Problems:
_____
__
Discuss Satisfaction Level at Work/School:
_____

**LEISURE/HOBBIES/ACTIVITIES: How do you spend your free time?**_____
_____
_____

**Please add any additional information you would like us to have.** _____
_____
_____
_____
_____

**Please describe in detail what you hope to get from your therapy sessions. In other words, what are the goals you hope to meet from this experience?** _____
_____
_____
_____
_____
_____