YOUTH ASSISTANCE FAMILY HISTORY

Name of Client: _____ **Date:** _____

Parent (or Legal Guardian)

	MOTHER	FATHER	STEPPARENT (LIVING WITH CHILD)
Name			
Address			
City, Zip			
Home Phone			
Work Phone			
Occupation			
Birth Date*			
Educational Level*			
Marriage Date			
Separation/Divorce Date			
Religion			
Race*			
E-Mail Address/Cell Number			

Family Income Range: ☐ $0-$15,000 ☐ $15,001-$30,000 ☐ $30,001-$45,000 ☐ $45,001-$60,000 ☐ $60,001 and above

Marital Status of Natural Parents: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Child lives in the household with these adults: (may check more than one)
☐ Parents ☐ Mother ☐ Father ☐ Stepparent ☐ Guardian ☐ Relative ☐ Live-in ☐ Other

Name of Health Insurance: _____

LIST CHILDREN IN THE FAMILY

Name (First and Last)	Age	Name of School (or Occupation)	Present Grade or Last Grade Completed	Living in This Household
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

*For Statistical Purposes Only

CHILD INFORMATION

Has your child ever been hospitalized? ☐ Yes ☐ No **Explain:** _____

Does your child have any physical problems? ☐ Yes ☐ No **Explain:** _____

Does your child take medication? ☐ Yes ☐ No **Name of Medication:** _____

Has your child ever lived outside of the home? ☐ Yes ☐ No **Explain:** _____

Is your child adopted? ☐ Yes ☐ No **If so, by whom:** _____

Has your child ever had psychological testing? ☐ Yes ☐ No _____

Has any member of your family received counseling or therapy? ☐ Yes ☐ No

Please provide as much of the following information as possible. Include contacts with other agencies, such as police, school social workers, court, Fairlawn, Protective Services, Child and Adolescent Clinic, private therapy, etc.

Family Member	Clinic/Agency	Counselor/Worker	Address/City	Phone	Dates

In the event of a scheduling conflict, please list the name and number of someone who may be contacted if we are unable to reach you.

Name: _____ **Phone:** _____ **Relationship to You:** _____

BEHAVIORAL CHECKLIST

If any of the following applies to your child (who was referred to this office), please check. Please indicate if the behavior is happening NOW or in the PAST or BOTH. NOW represents behaviors within the last six months. PAST represents behaviors present for longer than six months.

	Now	Past		Now	Past		Now	Past
Sleeping Difficulties			Verbally Abusive			Fighting		
Bedwetting			Cruelty/Bullying			Shows Off/Clowning		
Poor Eating Habits			Unusual Play Habits			Short Attention Span		
Completes Chores			Courteous/Polite			Lacks Self-Control		
Hyperactive			Plays With Younger Kids			Immature		
Reading Difficulty			Prefers Older Kids			Depression		
Repeated a Grade			Demands Attention			Suicidal		
Poor School Attendance			Good Peer Relations			Sharp Mood Swings		
Poor Grades			Respects Adults/Authority			Perfectionist		
Special Classroom			Disobedience			Active in Sports		
Behavioral Problems at School			Lying			Low Frustration Level		
Withdrawn/Shy			Stealing			Happy Child		
Outgoing/Friendly			Destructive			Sad Child		
Argues With Mother			Drugs			Lacks Guilt		
Argues With Father			Alcohol			Talks Too Much		
Argues With Siblings			Holds a Job			Good Personal Hygiene		
Clings to Adults			Running Away From Home			Acts Without Thinking		
Easily Jealous			Poor Choice for Friends			Nervous Child		
Insightful			Dependable/Reliable			Religious Activities		
School Activities			Cares for Animals			Highly Motivated		

What are your child's strengths and good points? _____

Weaknesses? _____

Comments: _____

Revised 09/03