

HANOVER TOWNSHIP
YOUTH AND FAMILY SERVICES
CLIENT HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to provide your therapist with information that can help with services to you and/or your family. **The information you provide is confidential and will not be shared without written permission.**

Demographic Information:

Date: _____

Client's First & Last Name: _____ **Birth date:** _____ **Age:** ____

Client's Preferred Name (if applicable): _____ **Pronouns:** _____

Address: _____ **City:** _____ **State/Zip:** _____

Phone Number: _____ **Email:** _____

Primary Language: _____

Interpreter Services: ☐None required ☐American Sign Language ☐TDD/TYY

☐ Spoken Language: _____ ☐ Other: _____

Gender: ☐Male ☐Female ☐Non-Binary ☐Prefer not to say

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic ☐ White
☐ Hawaiian Native/Other Pacific Islander ☐ Multi-Racial ☐ Other: _____ ☐ Prefer not to say

Ethnicity: ☐Hispanic ☐non-Hispanic ☐Other: _____ ☐Prefer not to say

Marital Status: ☐Single/Never Married ☐Married ☐Divorced ☐Domestic Partnership ☐Widowed

Educational Level: ☐Never Attended ☐Pre K/Kindergarten ☐In School, grade: _____

☐ H. S. Diploma/GED ☐ Some College ☐ Associate's degree ☐ Trade/technical training☐ Professional Certificate ☐ Bachelor's degree ☐ Master's/Doctoral degree

Guardianship Status: ☐Adult ☐Biological Parent ☐Adoptive Parent ☐Youth in Care

☐ Other court appointed ☐ Other: _____

Employment Status: ☐ Self-employed ☐ Student ☐ Homemaker ☐ Military ☐ Retired

☐ Unable to work ☐ Employed full-time ☐ Employed part-time ☐ Unemployed

Parent/Guardian: _____ **Relationship to Client:** _____

Address: _____ **City:** _____ **State/Zip:** _____

Phone Number: _____ **Email:** _____

Emergency Contact: _____ **Relationship to Client:** _____

Phone Number: _____ **Email:** _____

PROVIDE A LIST OF ALL THE INDIVIDUALS LIVING IN YOUR HOUSEHOLD:

[illegible]

MEMBERS OF THE ABOVE CLIENT'S IMMEDIATE FAMILY WHO LIVE ELSEWHERE

(Please include biological, adoptive, step, and foster children, parents and/or siblings):

First Name/Last Name	Relationship to Client	Birth date	Age

CURRENT STRENGTHS/CHALLENGES

1. Describe in your own words what made you decide to come to therapy: _____

2. When did you first notice what is bringing you into therapy: _____
3. What strengths do you (or your child) have that will be helpful to therapy: _____

4. What is something you are proud of about yourself (or your child): _____

FAMILY HISTORY

1. Has the referred client ever lived with anyone outside your immediate family: (please specify with whom and for how long): _____
2. Has anyone important to the client or the client's family died: (please specify who/and when): _____

3. Is there anything about your cultural background that you feel would be important for us to know? (Religious beliefs, Cultures the family is part of): _____

MEDICAL, PSYCHIATRIC AND THERAPY HISTORY

1. Does the client have a physician: ☐Yes ☐No
Doctor's Name: _____ Phone: _____ Address: _____
2. Does the client or any immediate family member have any current medical problems: ☐Yes ☐No
If yes, please specify: _____
3. List any current medication that the client is taking:

Medication	Amount	Prescribed by	Since When

4. During the last 6 months has the client had any significant changes (i.e., sleeping, weight, mood, concentration, etc.), life changes or major transitions? Please describe what kind of changes: _____

5. Has the client or another family member ever been psychiatrically hospitalized: ☐Yes ☐No

Name	Hospital	Dates	Did it help?

6. Has the client or another family member ever been in counseling or psychotherapy before: ☐Yes ☐No

Name	Agency/Therapist	Dates	Did it help?

SCHOOL HISTORY

1. Describe the client's academic performance for the past 6 months: _____

2. Has there been a change in the client's academic performance or school behavior in the past year: _____

3. Has the client ever received special educational services: ☐Yes ☐No
If yes, please specify the services: _____

4. Has the client ever received services from a school social worker: ☐Yes ☐No
5. Has the client ever received psychological or other specialized testing: ☐Yes ☐No
If yes, please specify any resulting diagnosis or recommendations: _____

COURT STATUS

1. Is the client being mandated to seek therapy services through a court order: ☐Yes ☐No
2. Does the client have a current open court case: ☐Yes ☐No
- 2.1. Please specify the circumstances of the client's current court involvement: _____

OTHER INFORMATION

Please list any other information that you feel is important: _____

Who completed this form: _____

If you need additional space, please feel free to use the back of this form. Thank you.