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PSYCHOLOGICAL & SOCIAL BACKGROUND SUMMARY – UNDER 18
(to be completed by parents of clients under 14)

Please provide the following information for our records. Leave blank any question you would rather not answer at present. Information you provide here is held to the same standards of confidentiality as our therapy. Please bring this form to your first session and allow yourself 30 minutes prior to your appointment to complete the form in the office. Thank you.

Name of parents/guardians (of minor):

(Last) (First) (Middle Initial) (Relationship)

(Last) (First) (Middle Initial) (Relationship)

Local Address: _____
(Street and Number)

(City) (State) (Zip)

Home Phone: () - May we leave a message? YES / NO

Work Phone: () - May we leave a message? YES / NO

Cell/Other Phone: () - May we leave a message? YES / NO

E-mail: _____ May we email you? YES / NO
(Please be aware that email might not be confidential.)

Name of client:

(Last) (First) (Middle Initial)

Birth Date: ____ / ____ / ____ Age: ____ Date: _____

Client's Siblings: _____

PRESENTING ISSUE

What is the problem for which you seek counseling for the client?

What have you done about this problem that has worked? How has it worked?

What have you done that has not worked? How do you know?

What emotions do you feel when you think about this problem?

On a scale of 1 to 10, low to high, how intense are these emotions when you think about the problem? _____

What other persons, if any, are affected by this problem?

What methods of discipline are currently used by parents?

What methods of discipline have been used by parents in past?

STRESS ISSUES

In the last year, has client experienced any significant life changes? If yes, please describe:

What level of stress is client experiencing at this time? (Check one.)

- Minimal Average Considerable Unbearable

What level of stress is being experienced by caregivers at this time? (Check one.)

Minimal Average Considerable Unbearable

What are the major factors of family stress at this time? (Check all that apply.)

Financial Marital Health Unfulfilled expectations
 Spiritual Career Family Children
 Body image Other _____

How do you know when client is stressed (use back, if need more space)?

How does the family cope with stress?

PHYSICAL CARE AND LIFESTYLE

How is the client's physical health at present? (please circle one)

Poor Unsatisfactory Satisfactory Good Very good Excellent

Please list any persistent physical symptoms or health concerns (e.g. asthma, diabetes):

Does client experience any disturbance in sleep? YES / NO

If yes, circle all that apply:

Sleeping too little Sleeping too much Poor quality sleep
Nightmares Other _____

How many hours, on average, does client sleep at night? _____

Any naps during the day, and if so, how many hours? _____

What time does client go to sleep at night? _____

Describe any other regular sleep disturbances, if any, and state how often:

Is client having any difficulty with appetite or eating habits? YES / NO

If yes, circle all that apply: Eating less Eating more Binging Restricting
Has client experienced significant weight change in the last 2 months? YES / NO

Describe weight changes, if any:

Does client smoke or has client experimented with smoking? YES / NO

If yes, how often? _____

Does anyone in your household smoke YES / NO

If yes, how many family members smoke: _____

Does client drink alcohol or has client experimented with alcohol? YES / NO

If yes, how often? _____

Does client use any recreational drugs? YES / NO

If yes, how often and what type? _____

How many main meals does client eat a day? _____ Times of day? _____

How many snacks a day? _____ Times of day? _____

In your opinion, does client have healthy eating lifestyle? YES / NO

Describe the reasons you think it is or isn't healthy:

Estimate how often client eats or uses the following (1 - rarely; 2 - regularly; 3 - often)

- Luncheon meats Candy Margarine Processed foods
 Cigarettes Microwave Fried foods Artificial sweeteners
 Aluminum pans Desserts Cooking wine Over the counter drugs

Indicate how many glasses or cups client drinks per day of the following:

- Coffee Tea Herbal tea Soft drink Diet soft drink
 Milk Water Wine

How many times per week does client exercise? _____

How long each time? _____

If applicable, what does client do for exercise?

How many hours, on average, per day does client spend:

Watching TV Reading In front of computer

What are clients' interests and hobbies, present and past?

PREVIOUS OR OTHER TREATMENT

Is client currently receiving professional counseling or therapy elsewhere? YES / NO

Is client currently receiving psychiatric services? YES / NO

If yes to either above, please list type of service, dates, problem, name and address of provider (if you need more space, use the back):

Is client currently taking prescribed psychiatric medication (i.e., antidepressants)? YES / NO

If yes, please list medication and dosage:

Has client received psychological services in the past? YES / NO

If yes, please list type of service, dates, problem, name and address of provider:

List any past medications (no longer taking), dosage and the reason each was prescribed:

Is client currently being treated for medical problems? In the past? YES / NO

If yes to either above, please list problem, dates, medication/dosage, name and address of provider (if you need more space, use the back):

DEVELOPMENTAL HISTORY

Date and place of birth: _____

Describe pertinent information during pregnancy, birth, and early development:

Describe any pertinent academic issues and educational experiences:

Has client experienced any of the following in the past or present (please circle):

Extreme depressed mood	YES / NO	Past / Currently
Wild Mood Swings	YES / NO	Past / Currently
Extreme Anxiety	YES / NO	Past / Currently
Panic Attacks	YES / NO	Past / Currently
Phobias	YES / NO	Past / Currently
Sleep Disturbances	YES / NO	Past / Currently
Hallucinations	YES / NO	Past / Currently
Frequent Body Complaints	YES / NO	Past / Currently
Eating Disorder	YES / NO	Past / Currently
Body Image Problems	YES / NO	Past / Currently
Repetitive Thoughts (e.g., Obsessions)	YES / NO	Past / Currently
Repetitive Behaviors (e.g., Checking, Hand-Washing)	YES / NO	Past / Currently
Homicidal Thoughts	YES / NO	Past / Currently
Suicidal Thoughts	YES / NO	Past / Currently
Suicidal Attempts	YES / NO	Past / Currently

FAMILY MENTAL HEALTH AND TREATMENT HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle yes or no to each, and list family member, e.g., Parent, Uncle, etc.):

<u>Difficulty</u>	<u>Family Member(s) Affected:</u>
Depression	YES / NO
Bipolar Disorder	YES / NO
Anxiety Disorders	YES / NO
Panic Attacks	YES / NO
Schizophrenia	YES / NO
Alcohol/Substance Abuse	YES / NO
Eating Disorders	YES / NO
Learning Disabilities	YES / NO
Trauma History	YES / NO
Suicide Attempts	YES / NO

Describe family history of psychological treatment, if any:

Describe family history of drug and/or alcohol dependency, if any:

Describe other pertinent factors in family history, i.e., abuse, trauma:

HOME ENVIRONMENT

Briefly describe child's relationship with each parent/caregiver:

Briefly describe child's relationship with siblings, if applicable:

Briefly describe child's relationship with friends, classmates, etc:

Describe other information regarding your home life that may be relevant to restoring child's mental, emotional, and physical health and wholeness:

OTHER INFORMATION

What do you consider to be client's strengths?

What do you like most about the client?

What are your goals for therapy?

FAMILY THERAPY

List any family members over the age of 10 you may want to include in family therapy in the future:

Have you considered, or are you willing to engage in couple therapy, if necessary (and applicable):

YES / NO / MAYBE

If YES, is your spouse or significant other, in your opinion, willing to engage in couple therapy, if necessary:

YES / NO / MAYBE