I LEARN
INNOVATIVE LEARNING PROFESSIONALS, LC

CLIENT HISTORY FORM

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Please complete this form for the client (the main person being seen) who will receive services (e.g., counseling, psychological assessment, or other interventions), whether that be yourself, your child, or someone else.

Full Name: _____ Date Completed: _____
first middle last

Birthdate: _____ Age: _____ Race/Ethnicity: _____

Education Level: _____ Marital/Relationship Status: _____

Religion/Faith: _____ Legal Status: ☐ Voluntary *or* ☐ Court Committed

Email: _____ Completed by: _____

ORIGINAL FAMILY (ex. parents, stepparents, siblings, half-siblings, stepsiblings, others who raised the client)

Name	Relationship	Age	Sex	Adopted	Lives With	Education	Occupation	Left or Right Handed
				Y N	Y N			
				Y N	Y N			
				Y N	Y N			
				Y N	Y N			
				Y N	Y N			
				Y N	Y N			
				Y N	Y N			
				Y N	Y N			
				Y N	Y N			
				Y N	Y N			

IF AN ADULT, CURRENT FAMILY (ex. spouse/significant other, children, stepchildren)

Name	Relationship	Age	Sex	Adopted	Lives With	Education	Occupation	Left or Right Handed
				Y N	Y N			
				Y N	Y N			
				Y N	Y N			
				Y N	Y N			
				Y N	Y N			
				Y N	Y N			
				Y N	Y N			
				Y N	Y N			
				Y N	Y N			
				Y N	Y N			

MAIN CONCERNS: What are your current concerns for the person seeking treatment or evaluation?

FAMILY HISTORY: Currently, how would you describe the client's general adjustment with others at home? How does the person get along with the family as a whole, as well as each person in the home?

If an adult, please provide basic information about the family in which the client grew up, the client's adjustment in it, and the client's perceptions of it.

PREGNANCY, BIRTH, AND DEVELOPMENTAL HISTORY: Check = yes in tables below

Pregnancy Specifics ☐ Unknown Check = yes in tables below			
☐	Were there complications?	☐	Did client's mother smoke/vape/use nicotine?
☐	Health problems during pregnancy?	☐	Drink alcohol?
☐	Did accidents/injuries occur in pregnancy?	☐	Use marijuana (or cannabis products)?
☐	Did the mother take medications?	☐	Use illegal drugs?

Please explain:

Labor and Delivery Specifics ☐ Unknown Complete known information, Check = yes in tables below		
Was client born full term? ☐ Yes ☐ No	☐	APGAR Ratings (if known):
How many weeks/months:	☐	Special Delivery Techniques: ☐Forceps ☐Vacuum-Assist
Birth Weight:	☐	Were there delivery complications?
☐Vaginal or ☐Cesarean	☐	Did the client fail to cry immediately at birth?
Length of Labor in hours:	☐	Client born with health problems?
Was Pitocin used? ☐ Yes ☐ No Hours used:	☐	Did client require special treatment at birth?

Please explain:

Adoption History ☐ Not applicable	Age when adopted
Number of placements prior to adoption:	☐ Private Adoption or ☐ DHS/System Adoption?
☐ Domestic or ☐ Foreign Adoption?	Client aware of own adoption ☐ Yes ☐ No

Please describe the circumstances surrounding the adoption, response to new home, and any other considerations or comments:

Infancy History ☐ Unknown Check = yes in tables below			
☐	Were there health concerns?	☐	Significant separations from primary caregivers.
☐	Were there sleeping problems?	☐	Attachment problems with primary caregivers.

Please explain:

Developmental History Specifics Check = yes in tables below			
Delayed	*Typical*	*Advanced*	
☐	☐	☐	Reached motor developmental milestones (rolling over, crawl, walk) on time
☐	☐	☐	Reached speech/language developmental milestones on time
☐	☐	☐	Reached overall developmental milestones on time.

Age when learned to: crawl _____ walk _____ speak first words _____ become toilet-trained _____
Please explain:

Additional Developmental Difficulties Indicate problems with any the following - when known: Check = yes in tables below			
☐	Coordination Difficulties	☐	Learning words for emotions (Alexithymia)
☐	Gross motor skills (e.g., roll, walk, run, hop)	☐	Understanding nonverbal communication (dyssemia)
☐	Fine motor skills (e.g., hand movements, write, bead, cut, pinch)	☐	Learning to do things automatically (automaticity)
☐	Balance	☐	Learning/understanding cause-and-effect
☐	Social Interaction (empathy, compassion, reciprocity, shyness)	☐	Learning concept of time & passage of time
☐	Development of play (alone, parallel, & with others)	☐	Sensory problems: sensitivities, avoidance, sensation seeking

Please explain:

Abuse and Trauma History ☐None Check = yes in tables below if experienced as a child or an adult					
Child	Adult		Child	Adult	
☐	☐	Neglect	☐	☐	Serious accident/injury
☐	☐	Emotional/psychological abuse	☐	☐	Significant losses
☐	☐	Physical abuse/assault	☐	☐	Experiences related to discrimination
☐	☐	Sexual abuse	☐	☐	War/Service-related (e.g., military/first responder)
☐	☐	Rape/sexual assault	☐	☐	Parental abuse of drugs/alcohol
☐	☐	Domestic abuse/violence (to self)	☐	☐	Foster careplacement/parental abandonment
☐	☐	Witness abuse of others	☐	☐	Other trauma

Please explain:

EDUCATIONAL HISTORY:

Current or highest grade completed/Highest degree obtained: _____

If a child: Current School: _____ Current grade: _____ GPA/Average Grades: _____

If an adult: Name of high school: _____ GPA: _____ Year of Graduation: _____

Name of college/university/professional/technical schools: _____

GPA: _____ Year(s) of Graduation: _____

Special considerations regarding school: ☐ None Check = yes in tables below

☐	Special Education/IEP	☐	Did not apply self	☐	Substance problems at school
☐	504 Plan of Accommodations	☐	Behavior problems	☐	Bringing weapons to school
☐	Learning Disability	☐	Truant/Tardy	☐	Violence at school
☐	Difficulty learning	☐	Suspension(s)	☐	Bullying
☐	Developmental Disability	☐	Expulsion(s)	☐	Other

School Contact Person(s)!(if applicable): _____

Comments:

RELATIONSHIP HISTORY: ☐ None
Please describe the client's relationship history (dating, significant others, marriage, etc.):

MENTAL HEALTH HISTORY:

Other Current Mental Health Providers: _____ Check = yes in tables below

now	past	Mental Health History Problem	now	past	Mental Health History Problem
☐	☐	Learning disability	☐	☐	Autism Spectrum Disorder
☐	☐	Intellectual limitations	☐	☐	Other developmental disorder
☐	☐	Speech/language disorder	☐	☐	Tourette's/tic disorder
☐	☐	Brain injury (concussion/head injury/stroke)	☐	☐	Auditory processing disorder
☐	☐	Anxiety disorder	☐	☐	Attachment disorder
☐	☐	Panic Disorder	☐	☐	Schizophrenia/psychosis
☐	☐	Phobia/Intense fears	☐	☐	Alcohol abuse
☐	☐	Obsessive Compulsive Disorder	☐	☐	Substance use
☐	☐	Trauma-related disorder (e.g., PTSD)	☐	☐	Personality disorder
☐	☐	Depression	☐	☐	Sexual acting out
☐	☐	Bipolar disorder (manic depression)	☐	☐	Somatoform/conversion/pseudoseizure disorder
☐	☐	Eating disorder	☐	☐	Sexual Gender Identity concerns
☐	☐	ADHD/ADD	☐	☐	Issues related to discrimination
☐	☐	Oppositional Defiant Disorder	☐	☐	Outpatient counseling
☐	☐	Conduct Disorder	☐	☐	Inpatient hospitalization
☐	☐	*Suicidal ideation******	☐	☐	Partial hospitalization
☐	☐	*Homicidal ideation******	☐	☐	Residential placement
☐	☐	*Self-harm (e.g., cutting/burning)******	☐	☐	Court-ordered treatment

***Please be aware that this history form is not reviewed prior to your appointment. If you are currently unable to keep yourself or others safe, please call 911 or go to the nearest emergency room.**
Please explain mental health/emotional/behavioral history:

MEDICAL HISTORY:

Current physical health: ☐good ☐fair ☐poor *Primary Care Provider*: _____

Check = yes in tables below

now	past	Medical History Problem	now	past	Medical History Problem
☐	☐	Genetic disorder	☐	☐	Gastro-intestinal (stomach) problems
☐	☐	Head Injury	☐	☐	Heart Disease
☐	☐	Seizures/Epilepsy/Etc.	☐	☐	Hepatitis
☐	☐	High Fever (how high:)	☐	☐	High Blood Pressure/Hypertension
☐	☐	Meningitis/similar neurological virus	☐	☐	Infectious Disease
☐	☐	Stroke/Transient ischemic attack (TIA)	☐	☐	Kidney Disease
☐	☐	Headaches(migraines tension cluster)	☐	☐	Liver Disease
☐	☐	Hospitalization	☐	☐	# of Pregnancies # of Live Births
☐	☐	Allergies	☐	☐	Pregnancy Problems/Complications
☐	☐	Anemia	☐	☐	Respiratory problems/Lung Disease/COPD
☐	☐	Arthritis	☐	☐	Serious accident/injury
☐	☐	Asthma	☐	☐	Sexually Transmitted Infections (STI/STD)
☐	☐	Back Problems	☐	☐	Skin problems
☐	☐	Bed wetting (nocturnal enuresis)	☐	☐	Sleep problems
☐	☐	Broken bones	☐	☐	Stomach Ulcers
☐	☐	Cancer	☐	☐	Strep Throat (severe/recurrent)
☐	☐	Chronic pain	☐	☐	Surgery
☐	☐	Diabetes	☐	☐	Tuberculosis (TB)
☐	☐	Ear infections (severe/recurrent)	☐	☐	Thyroid Disorders
☐	☐	Enuresis/encopresis (daytime toileting accidents)	☐	☐	Other:

Please explain:

Current Medications: ☐None **or** Please indicate name of medication, dose, frequency, and side effects for each

Vision:

Are there any problems with eyesight or vision? ☐ Yes ☐ No Does client need corrective lenses? ☐ Yes ☐ No

Perceptual difficulties when reading (e.g., the words get blurry, letters blend or move, double images form)? ☐ Yes ☐ No

Assuming corrected vision, is there any difficulty understanding/using what is seen? ☐ Yes ☐ No

When was the last time eyesight was tested? _____

Please explain any 'Yes' answers above and describe any problems (past or present) with vision (or visual processing) including vision loss, operations, previous treatments, etc.:

Hearing:

Are there any problems with hearing? ☐ Yes ☐ No Does client need hearing aids? ☐ Yes ☐ No

Assuming corrected hearing, is there difficulty understanding, responding to, or using what is heard? ☐ Yes ☐ No

As a child were ear infections: ☐ seldom ☐ sometimes ☐ frequent? Were they ☐ mild ☐ moderate ☐ severe?

When was the last time hearing was tested? _____

Please describe/explain any problems (past or present) with hearing (or auditory processing) including hearing loss, tube placement, operations, etc.:

Sleep:

Does client: sleep through the night? ☐ Yes ☐ No wake rested? ☐ Yes ☐ No

snore? ☐ Yes ☐ No stop breathing while sleeping? ☐ Yes ☐ No

Does client have problems ☐ falling asleep ☐ waking up in the middle of the night ☐ waking up too early?

At what time does client typically go to bed? _____ Get up? _____

How many hours does client need to feel rested? _____ How many hours sleep does client typically get?_____

How much caffeine in a typical day? _____ How many energy drinks in a typical day? _____

Comments:

Nutrition/Eating/Body Image/Weight:

Number of Meals per Day: _____ Height & Weight (optional): _____

Please check those that apply (Check = yes in tables below)			
☐	Has a healthy relationship with food and/or body	☐	Binge eating and/or purging
☐	Concerns about weight	☐	Excessive/obsessive exercise
☐	History of being overweight/obese	☐	Eating when stressed/anxious/depressed
☐	Dieting/restricting history	☐	Celiac or gluten-sensitivity
☐	History of eating disorder	☐	Issues with body image/body shame

How often does client exercise and eat/drink the following:

	Several times a day	Daily	Several times a week	A few times a week	Weekly	Monthly	Very rarely
Frequency of Exercise:	☐	☐	☐	☐	☐	☐	☐
Frequency of Aerobic Exercise	☐	☐	☐	☐	☐	☐	☐
Dairy products	☐	☐	☐	☐	☐	☐	☐
Food containing gluten (wheat, barley, rye)	☐	☐	☐	☐	☐	☐	☐
Whole grains	☐	☐	☐	☐	☐	☐	☐
Red meat	☐	☐	☐	☐	☐	☐	☐
Poultry	☐	☐	☐	☐	☐	☐	☐
Green leafy vegetables	☐	☐	☐	☐	☐	☐	☐
Other vegetables	☐	☐	☐	☐	☐	☐	☐
Fresh fruit	☐	☐	☐	☐	☐	☐	☐
Home cooked meals	☐	☐	☐	☐	☐	☐	☐
Fast food meals	☐	☐	☐	☐	☐	☐	☐
Refined carbohydrates & sugars	☐	☐	☐	☐	☐	☐	☐
Processed foods	☐	☐	☐	☐	☐	☐	☐
Soda pop	☐	☐	☐	☐	☐	☐	☐

Comments on Eating, Nutrition, Body Image, and Weight:

BIOLOGICAL FAMILY MEDICAL & MENTAL HEALTH HISTORY:

Conditions running in mother's and father's sides of family: Check = yes in tables below

Maternal	Paternal	**Mental Health Condition**	Maternal	Paternal	**Medical Condition**
☐	☐	Unknown	☐	☐	Unknown
☐	☐	Anxiety Disorders	☐	☐	Alzheimer's/Dementia
☐	☐	Depression	☐	☐	Seizures/Epilepsy/Etc.
☐	☐	Bipolar Disorder	☐	☐	Stroke/Transient ischemic attack (TIA)
☐	☐	ADHD/ADD	☐	☐	Cancer
☐	☐	Schizophrenia/psychosis	☐	☐	Diabetes
☐	☐	Autism spectrum disorders	☐	☐	Heart Disease
☐	☐	Intellectual limitations	☐	☐	High Blood Pressure
☐	☐	Learning disabilities	☐	☐	Thyroid Disorders
☐	☐	Behavior/conduct/defiance problem	☐	☐	Sleep problems/apnea
☐	☐	Alcohol abuse	☐	☐	Headaches
☐	☐	Drug abuse	☐	☐	Genetic disorders
☐	☐	Suicide	☐	☐	Other neurological conditions
☐	☐	Eating disorders	☐	☐	Other:
☐	☐	Other:	☐	☐	Other:
☐	☐	Other:	☐	☐	Other:

Comments:

SUBSTANCE USE HISTORY:

Substances used: ☐None ☐Unknown Check = yes in tables below

recent	past	Substance	recent	past	Substance
☐	☐	Alcohol	☐	☐	MDMA/Ecstasy
☐	☐	Beer	☐	☐	Barbiturates
☐	☐	Wine	☐	☐	Inhalants
☐	☐	Hard liquor	☐	☐	Benzodiazapines (e.g., Xanax, clonazepam)
☐	☐	Marijuana/Cannabis/THC	☐	☐	Over-the-counter drugs used recreationally
☐	☐	Opiates (Heroin, pain killers, etc)	☐	☐	Prescription Medications used recreationally
☐	☐	Amphetamine	☐	☐	Tobacco
☐	☐	Methamphetamine	☐	☐	Vaping/e-cigarettes
☐	☐	Cocaine/Crack	☐	☐	Caffeine
☐	☐	Hallucinogens (LSD/acid, mushrooms, etc)	☐	☐	Other

Previous Substance Abuse Treatment (check all that apply):
☐None ☐Outpatient ☐Day/Partial ☐Detox ☐Inpatient ☐Residential ☐Recommended But Not Done
Genetic Alcohol/Drug Abuse Family History (check all that apply):
☐None ☐Immediate Family ☐Maternal Extended Family ☐ Paternal Extended Family
Comments:

EMPLOYMENT HISTORY: ☐ None
(present employment, type of work done, work history, stability of work)
Comments:

MILITARY HISTORY: ☐ None ☐ Branch Served: _____

Year Entered: _____ Year Exited: _____ Exit Rank: _____ Type of Discharge: _____

Service-Related Trauma Experiences: ☐yes ☐no

Comments:

LEGAL HISTORY: ☐None ☐Probation ☐Jail ☐Prison ☐Parole
Is/was there a ☐ Juvenile Court Officer ☐ Probation/Parole Officer ☐ DHS Worker
Current JCO/PO/DHS Worker Name (if applicable): _____
Please explain past charges and circumstances:

PRIOR ASSESSMENT HISTORY

Has the client had any previous assessments? ☐None

Type of previous assessments	Yes	Place	Date
Medical	☐		
Audiological	☐		
Speech and/or Language	☐		
Educational	☐		
Psychological	☐		
Psychiatric	☐		
Other	☐		
Other	☐		

Please provide copies of reports of past assessments. If they are not available, please describe any significant results from previous assessments or provide other general comments.

OTHER RELEVANT INFORMATION/COMMENTS:

Submit Form to David Beeman, Ph.D.

Submit Form to Dusty Baker, Ph.D.

Submit Form to Susan Helkenn LISW

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