Youth Client History- Parent Report

The information on this form is confidential. We will not share it with anyone outside of Shine A Light Counseling Center without your written consent, except in case of emergency or when required by law.

This form is to be filled by a parent presenting a youth for therapy. If you are a youth presenting yourself for therapy, please ask your therapist for the correct form.

Basic Information
Name of Person completing this form: Date:
Your relationship to the youth:
Youth's Name: Youth's Medi-Cal ID#:
Youth's Birthdate: Age:
Youth's Phone: Youth's Email:
Youth's Home address:
How does your child prefer to be contacted? ____ Call ____ Text ____ Email
Phone messages: Is it ok for us to identify ourselves as from Shine A Light? ____ Y ____ N
What race does your child identify with:
What gender does your child identify with:
Parent's Relationship Status:
Legal Custody: ____ Joint ____ Sole. If Sole, Which parent? _____
Do both parents consent to counseling for the child?

Safety Issues

Has your child ever attempted suicide? ____ Yes ____ No

If yes, what are the dates:

Has your child had thoughts of suicide in the last year? ____ Yes ____ No

Has your child been thinking about suicide recently? ____ Yes ____ No

If yes, please elaborate:

Reason for Seeking Treatment

What concerns cause you to seek counseling for your child?:

What are your goals for your child in relation to this therapy?:

Which of the following affect your child? (check all that apply)

- ❑ Anxiety
- ❑ Depression
- ❑ Anger
- ❑ Grief
- ❑ Loneliness
- ❑ Relationship conflict
- ❑ Chronic pain
- ❑ Addiction
- ❑ Anorexia
- ❑ Bulimia
- ❑ Overeating
- ❑ Impulse control
- ❑ Sleep problems
- ❑ Difficulty concentrating
- ❑ Fatigue
- ❑ Panic attacks
- ❑ Phobias
- ❑ Emotional trauma
- ❑ Sexual issues
- ❑ LGBTQ issues
- ❑ High stress
- ❑ Poor communication
- ❑ ADHD

Which statements feel true for your child? (check all that apply)

- ☐ I feel tense most of the time.
- ☐ I have a lot of physical problems that can't be explained.
- ☐ I worry most of the time.
- ☐ I do some things over and over for no good reason.
- ☐ I have nightmares and/or flashbacks that I can't get out of my head.
- ☐ I sometimes feel shaky or unable to relax.
- ☐ I avoid social situations because I am fearful.
- ☐ There are some things I am really afraid of.
- ☐ I am afraid to leave the house.
- ☐ I can't concentrate because I have so many thoughts running in my head.
- ☐ I no longer have any interest in the things that used to interest me.
- ☐ I sometimes hurt myself intentionally.
- ☐ I spend a lot of time with video games.
- ☐ I get tired for no reason.
- ☐ I am sleeping too much, or too little.
- ☐ I feel unhappy.
- ☐ I become irritable or anxious easily.
- ☐ I have spontaneous urges to cry.
- ☐ I feel really self-confident lately.
- ☐ I feel happier or more cheerful than usual.
- ☐ I notice that I need less sleep than usual.
- ☐ I can't make decisions because I have a difficult time concentrating.
- ☐ I feel sluggish and restless.
- ☐ I am gaining or losing weight without trying to.
- ☐ I talk more frequently and find it difficult to be interrupted.
- ☐ I am more active or "on the go" than usual.
- ☐ I feel hopeless about the future.
- ☐ I spend a lot of time on social media

Psychiatric History

Has your child ever been admitted to a psychiatric hospital? If so, please briefly explain circumstances and provide dates and diagnoses (to the best of your recollection):

Has your child ever seen a psychotherapist before? If so, please provide dates and a brief explanation of the focus of your therapy:

Trauma History

What hardships affected your child growing up?

What hardships affect your child now?

Family Psychiatric History

Please list any mental health or substance use related issues of family members

Mother:

Father:

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather:

Sibling:

Sibling:

Medical Conditions and History

What medical issues are your child dealing with, or have been significant in their past?:

What medications are your child currently taking (including psychiatric)?:

What medications have your child been on previously (including psychiatric)?:

Substance Use History

Has your child ever been treated for substance use? If so, what were the dates?

Does your child use any recreational substances, to your knowledge?

Which substances (alcohol or drugs)?

In what amount and frequency does your child use these substances?

Family and Social History

Name of Parent/Guardian #1: _____ Phone: _____

Education Level:_____ Employment:_____

Name of Parent/Guardian #2: _____ Phone: _____

Education Level:_____ Employment:_____

Who does your child live with? (Check all that apply)

____ Parent/guardian #1 all the time ____Parent/guardian #2 all the time

____ Parent/guardian #1 some of the time ____ Parent/guardian #2 some of the time

Please list all other family members your child lives with, and their ages:

Are there any current or past issues between your child and another family Member? Describe:

Would you or another family member like to be involved in your therapy in any way? How?:

Does your child appear to have trouble making friends?

Does your child have any current or past issues with their social relationships?

Do you identify with a religion or spiritual practice?

What are your child's favorite hobbies?

Education & Occupation

What grade is your child in?

What school does your child go to?

Does your child have a job? If yes, where?

Has your child ever been suspended or expelled from school or fired from a job? If yes, why?

Legal History

Has your child ever been charged with a crime? If so, briefly describe:

Are you now, or might you soon be involved in a lawsuit regarding custody or anything else relating to your child?

Strengths and Limitations

Please identify your child's top three strengths:

Please identify your child's top three limitations:

Additional Information

Do you have any concerns regarding your child's therapy?

Is there anything else you want your child's therapist to know?

Thank you for your information. We look forward to working with your child.