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Child / Adolescent Questionnaire Form | Page 1

Client's Name: | **Birth Date:** (Month) (Day) (Year) | **Age:** | **Gender:**

Name of Person Completing this form: | Relationship to Patient: | Date Completed: (Month) (Day) (Year)

Dear Parent: *The information that you provide is critical in providing an accurate diagnosis and treatment of the problem. If you require additional space to answer any of these questions, there is an entire page at the end of this interactive form where you can provide additional details. Please reference the question you are answering when providing the extra information. If you do not know the answer to any of the questions that follow, please indicate N/K. If the question does not apply, please indicate N/A.*

Please check ALL of the following symptoms that you have seen that apply to the client AT THIS TIME OR DURING THE PAST SIX MONTHS:

- ☐ Depressed mood
- ☐ Diminished interests or pleasure
- ☐ Sleep disturbance
- ☐ Fatigue
- ☐ Change in appetite
- ☐ Hopelessness
- ☐ Pleasure in few activities
- ☐ Weight change
- ☐ Agitation
- ☐ Excessive worry
- ☐ Irritability
- ☐ Poor concentration
- ☐ Tension
- ☐ Socially withdrawn
- ☐ Anxiety in social settings
- ☐ Makes careless mistakes
- ☐ Does not complete tasks
- ☐ Difficulty organizing
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Disorientation
- ☐ Compulsive Checking / Counting
- ☐ Indecisiveness
- ☐ Distracted from conversations / interactions
- ☐ Excessive time spent on social media
- ☐ Excessive time spent on gaming systems
- ☐ Paranoia
- ☐ Hearing voices / sounds others do not hear
- ☐ Seeing things others do not see
- ☐ Smelling things others do not smell
- ☐ Reported racing thoughts
- ☐ Participation in risky or dangerous activities
- ☐ Sexual promiscuity
- ☐ Gender concerns
- ☐ Critical of personal appearance and body image
- ☐ Binge eating
- ☐ Excessive fasting
- ☐ Purging food
- ☐ Intense fear of weight gain
- ☐ Behaviors specially intended to change weight or appearance
- ☐ Impulsiveness
- ☐ Difficulty in school
- ☐ Reported thoughts of self-hurting
- ☐ Attempted self-harm
- ☐ Reported self-harm intent
- ☐ Reported thoughts of hurting others
- ☐ Recurring distressing dreams
- ☐ Exposed to a significant traumatic event
- ☐ Use of tobacco
  Amount / frequency:
- ☐ Use of alcohol
  Amount / frequency:
- ☐ Use of other substances
  Please list substances and the amount / frequency:
- ☐ Other:

Please describe, in detail, the present problem (including when the problem started, how long it has been a problem, how often it occurs, what stressors may contribute to the problem, etc.)

Has your child ever received psychiatric services or counseling? ☐ No ☐ Yes

If yes, please indicate with whom, frequency / length of treatment, and progress / changes from treatment:

Developmental History

A. Relating to your child's birth:

Your child's weight at birth: ☐ (lbs) ☐ (oz)

Was this a full-term birth? ☐ No ☐ Yes
If no, please explain:

Did either parent use drugs or alcohol at the time of conception or during pregnancy? ☐ No ☐ Yes
If yes, please explain:

Were there any complications with the labor & delivery such as jaundice, infection, etc? ☐ No ☐ Yes
If yes, please explain:

Were there any problems after birth? ☐ No ☐ Yes
If yes, please explain:

B. Preschool / Toddler Temperament - Please check the following items that apply:

- ☐ Did not enjoy being held
- ☐ Excessive restlessness
- ☐ Colic
- ☐ Feeding problems
- ☐ Head-banging
- ☐ Fussy or unhappy
- ☐ Difficulty bonding
- ☐ Sensitive to light / noise / texture

C. Developmental Milestones:

Please indicate the approximate age in months when your child achieved the following tasks:

Sitting alone ☐ Walking ☐ Put words together ☐ Toilet trained ☐

D. Unusual behaviors / speech patterns - Please check the following items that apply:

- ☐ Spinning
- ☐ Putting things in mouth
- ☐ Repeating words or phrases inappropriately
- ☐ Hand flapping
- ☐ Sniffing excessively
- ☐ Saying "I" for "You"

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School / Daycare History

Did your child attend daycare? ☐ No ☐ Yes If yes, what was their age? _____

Any problems while in daycare?

_____

What were the client's grades on their last report card?

_____

What is the name of the client's current primary teacher?

_____

Name of current school: _____ Dates attended: _____ Present grade: _____

Behavior problems? ☐ No ☐ Yes If yes, please describe: _____

Learning problems? ☐ No ☐ Yes If yes, please describe: _____

Has your child ever been evaluated for a learning disability? ☐ No ☐ Yes _____
If yes, what grade and when?

Has your child ever been placed in Special Education Classes? ☐ No ☐ Yes _____
If yes, what type of class?

Has your child ever been tested by the school system? ☐ No ☐ Yes _____
If yes, when?

Has your child ever been expelled or suspended? ☐ No ☐ Yes _____
If yes, please describe.

Does your child have a current IEP (Individual Education Plan)? ☐ No ☐ Yes

Does your child have a current 504 plan? ☐ No ☐ Yes

Name of previous schools:	Dates attended:	Grade placement:	Behavior Problems?	Learning problems?
			☐ No ☐ Yes	☐ No ☐ Yes
			☐ No ☐ Yes	☐ No ☐ Yes
			☐ No ☐ Yes	☐ No ☐ Yes

If you need more space to provide details regarding behavior or learning problems, or other issues regarding school / daycare history, please use the space below and provide as much detail as possible:

Legal / Juvenile Court / Alabama State Department of Human Resources (DHR)

Has your child:

ever been arrested? ☐ No ☐ Yes

been assigned a probation officer? ☐ No ☐ Yes _____ If yes, their name?

ever been jailed? ☐ No ☐ Yes

ever appeared in juvenile court? ☐ No ☐ Yes

Has your child or other family member ever been:

reported to DHR? ☐ No ☐ Yes

assigned a DHR caseworker? ☐ No ☐ Yes _____ If yes, their name?

a victim of child physical or sexual abuse? ☐ No ☐ Yes

If you answered yes to any of these questions, please explain:

Family History

In the section below identify ***if there is a family history*** of any of the following. If yes, please indicate the family member's relationship to the client in the space provided **(father, mother, siblings, uncle, etc.).** ***If unsure, leave blank.***

Alcohol / Substance Abuse ☐ No ☐ Yes

Anxiety ☐ No ☐ Yes

Depression ☐ No ☐ Yes

Divorce / Marriage Problems ☐ No ☐ Yes

Domestic Violence ☐ No ☐ Yes

Eating Disorders ☐ No ☐ Yes

Obsessive Compulsive Behavior ☐ No ☐ Yes

Schizophrenia ☐ No ☐ Yes

Suicide Attempts ☐ No ☐ Yes

Bi-Polar Disorder ☐ No ☐ Yes

Other mental health issues:

Other Family Medical History

Please indicate if the client has a family history of the following:

- ☐ Sudden death
- ☐ Heart disease (especially dysrhythmias)
- ☐ Diabetes mellitus
- ☐ Obesity
- ☐ Narrow Angle Glaucoma
- ☐ Seizures

Are you requesting any cultural or religious considerations? ☐ No ☐ Yes

If yes, please explain.

Has the client previously been in counseling or treated in any way by a mental health professional? ☐ No ☐ Yes

If yes, with whom?

Was it a helpful experience?

IN THE PAST has the client been prescribed medication for a psychological disorder? ☐ No ☐ Yes

If yes, please list.

Is the client **CURRENTLY** taking **ANY** prescription medication? ☐ No ☐ Yes

If yes, please list.

General Health Information

Primary care doctor:

Office phone:

Date last seen:

Has the client ever received treatment for any Chronic Medical conditions? ☐ No ☐ Yes

If yes, please describe.

Does the client have a history of Past surgeries? ☐ No ☐ Yes

If yes, please describe.

Has the client been the victim of any of the following traumas?

- Sexual abuse as a child or teen ☐ No ☐ Yes
- Victim of sexual assault ☐ No ☐ Yes
- Victim of physical abuse ☐ No ☐ Yes
- Victim of verbal / psychological abuse ☐ No ☐ Yes
- Witnessed the traumatic death or abuse of another person ☐ No ☐ Yes
- Head injury needing medical treatment ☐ No ☐ Yes

Please provide any additional information you believe is needed for the counseling process regarding traumas experienced:

Social / Family History

Biological mother's full name:

Biological father's full name:

Biological parents marital status: ☐ Married to each other ☐ Divorced ☐ Separated

If the biological parents are divorced or separated, who has custody of the patient?

Type of custody?

If divorced from one another, has either remarried? Mother ☐ No ☐ Yes Father ☐ No ☐ Yes

Stepmother's name:

Stepfather's name:

List all relatives who presently live in the same household as your child:

Name	Relationship	Type of Employment / Student Grade Level

Has the client ever lived with anyone other than those listed above? ☐ No ☐ Yes

If yes, please explain.

Please check any of the following stressors that presently affect the client within their home environment:

- ☐ Family financial problems
- ☐ Family relationships
- ☐ Legal problems
- ☐ Child rearing problems
- ☐ Drug or alcohol problems
- ☐ Abuse behavior
- ☐ Health problems
- ☐ Employment problems
- ☐ School problems
- ☐ Peer relationships
- ☐ Frequent change of household
- ☐ Frequent moves
- ☐ Other:

Please provide any additional information needed regarding any item you checked:

Additional Information

If you need any additional space to answer questions or provide information, you may use the space below. Please reference any question you are providing more details about, and please provide as much detail as possible.