CHILD AND ADOLESCENT QUESTIONNAIRE

DATE __/__/__

PATIENT NAME_____ **BIRTH DATE**__/__/__ **AGE**_____

NICKNAME(s) usually used:_____ **SEX:** Male ____ Female ____

CHILD'S LEGAL GUARDIAN(S):_____
If the legal guardian is NOT the biologic or adoptive parents: guardianship documentation must be provided.

REASONS FOR SCHEDULING AN APPOINTMENT

HOUSEHOLD INFORMATION

LIST WHO LIVES IN THE CHILD'S HOME:

NAME	SEX	AGE	RELATIONSHIP TO CHILD

List the occupations of the adults who live in the home and how many hours worked out side the home per week:

First Name	Occupation	Hours worked/week (average)

Describe how the child gets along with the children and the adults who live in the child's home.

Residences: Number of times child has moved since born: _____ Date of most recent move _____

CARETAKERS: Does the child spend time with primary care givers other than parents?
No ___ Yes ___ Please list:

FAMILY RELATIONSHIP: Is the child **ADOPTED**? No ___ Yes ___ If yes. age of child when adopted _____
Is the child a **FOSTER** child? No ____ Yes ___ If yes, list caseworker's name and telephone number:

Caseworker's name _____ Phone number _____ County _____

OTHER IMPORTANT PERSONS:
List parents, siblings (biologic, step or adoptive), and other important relatives not currently living in home:

NAME	AGE	CITY	RELATIONSHIP	FREQUENCY SEEN

Describe how the child gets along with the above persons:

IF the above list includes a parent, list Address and home & work Phone Numbers:

Name:_____

Address:_____

Home Phone:_____ Work Phone:_____

CHILD'S BIOLOGIC OR ADOPTIVE PARENTS ARE NOW:

NEVER MARRIED: And together ___ And separated ___ List date separated_____
MARRIED ____ How many years?_____
SEPARATED ___ List date separated_____
DIVORCED ___ List date divorced _____
Has either parent remarried? No ___ Yes ___ If yes, when? : Mother _____ Father _____
DECEASED: ___ List relationship and date deceased:_____

CUSTODY AND VISITATION
If divorced or separated, what is the custody arrangement and what is the visitation arrangement?
How well do these arrangements work? Not Applicable _____

SOCIAL AGENCIES: Please list any welfare, children's services connections, or social agencies
Involved with your family: None ____

CHILD HEALTH INFORMATION:

ALLERGIES:

Medication Allergies: None ___ Yes: List _____

Other allergies: None ____ Yes: List _____

PHYSICIANS:

Family MD or Pediatrician: _____

Date of child's last physical: _____

List any specialists your child sees: _____

IMMUNIZATIONS: Up to date? Yes ____ No ____ Explain:

MEDICATIONS: Please list all current medications; both prescription and over the counter taken on a regular basis.

Medication	Dosage	Reason

MEDICAL CONDITIONS: List all medical problems and indicate if past or current:

Condition	Past	Current

PHYSICAL HANDICAPS OR CHALLENGES: (visual, hearing, motor, physical, etc.) None ____ Yes: Describe:

SLEEP: Average hours of sleep per night? _____ Child sleeps: Soundly ___ Fitfully or Restlessly ____

Has bad dreams: Never ___ Occasionally ___ Frequently ___

Do you have concerns about sleep or bedtime? No ___ Yes ___ Describe:

NUTRITION: Appetite is usually: Good ___ Excessive ___ Poor ___ Variable ___

Do you have any concerns about the child's eating patterns or nutrition? No ___ Yes ___

Does the child have any difficulty with eating or swallowing? No ____ Yes ____ -

Is there history of vomiting___, bingeing___, excessive dieting___, excessive preoccupation with food___?

Comments:

MENSTRUATION: Not applicable ___ Has menstruation begun? No ___ Yes ___

If so, at what age? ___ Has menstruation been: Painful ___ Irregular ____

Do you think there are excessive signs of PMS? No ___ Yes ___

Comments:

TOBACCO: Does child smoke or use Tobacco? No _____ Yes _____

DRUGS & ALCOHOL: Does child use/abuse alcohol? No ___ Yes ____
Does child use/abuse drugs/illegal substances? No ____ Yes ____ Comments:

SEXUAL: Do you or your child have any sexual or sexuality concerns? No ____ Yes ____ Comments:

CHILD DEVELOPMENTAL HISTORY:

PRENATAL AND BIRTH HISTORY: Birthweight: _____ Premature ____ Full Term ____
List any problems with the pregnancy or delivery: None ___ Comments:

DEVELOPMENTAL MILESTONES:
INFANCY: Birth to two years. List any significant delays/problems such as feeding problems or Slow to walk or talk:
None _____ Comments

TODDLER / PRESCHOOL : 2 - 5 years. List any developmental delays or difficulties such as trouble with toilet training, speech or self care: None ____ Comments:

SCHOOL AGE: 8 to 12 years of age: List any delays I problems such as attention problems, school refusal or early puberty: Not applicable ____ None ____ Comments:

MIDDLE / HIGH SCHOOL: 13 to 18 years: describe any delays/problems:
Not applicable ___ None ____ Comments:

FAMILY MEDICAL HISTORY: List the relationship of the family member and any details if applicable:
List any significant medical problems in the immediate family or close relatives? None ____ Comments:

List any history of genetic illness or developmental illnesses (mental retardation, autism, Huntington's Chorea, Sickle Cell, etc)?: None ____ Comments:

List any family history of emotional problems (nervous breakdowns, depression, obsessive/compulsive, anxiety, schizophrenia, bipolar, etc)? No ____ Comments:

List any family history of suicide? None ____ Comments:

List any family history of substance abuse or addictions? None ____ Comments:

PAST COUNSELING AND PSYCHIATRIC TREATMENT:
List any inpatient hospitalizations: None ___ Comments:

List any partial hospitalizations or Intensive Outpatient Treatment (IOP): None ____ Comments:

List any previous counseling with provider and date: None _____ Comments:

List any medicines used in the past for emotional or behavioral problems: None ____ Comments:

CHILD SOCIAL HISTORY:
SCHOOL INFORMATION: (If in Day Care or Preschool, please fill out as applicable)
Name of School _____

Present Grade Level_____ Special Placement or Classes?_____
Does child have an IEP?_____ Does child have a learning disability? _____

Current Teacher_____ Counselor _____

Began school at what age? _____ Adjusted to school: Easily ____ With Difficulty ____
Repeated what grade? None ___ If Yes, list what Grade(s):_____

Has child had psychoeducational testing done? No ____ Yes ____ If yes, explain:

Most Grades have been: A B C D F Current GPA if known: _____

When, if ever, did work begin declining? _____

How does your child best learn? Reading ____ Hearing ____ Watching ____ Hands On ____

Expulsions / Detentions / Suspensions? None ___ Yes ___ Comments:

Describe relationships with other students and teachers:

Other school concerns:

LEISURE, HOBBIES, PLAY: What does your child enjoy doing in his/her free time? What social activities, extracurricular activities, lessons or sports is he/she involved in?

What kinds of activities does your **FAMILY** enjoy together?

FRIENDS / SOCIAL: List any concerns about your child's relationships with other children: None ___ Comments:

STRENGTHS AND DIFFICULTIES: What strengths or talents does your child have?

What difficulties or limitations does your child have?

CULTURAL: Are there any family or cultural values or traditions we need to know about? (Customs, ethnicity, foods, military service, religious practices, etc.): No ____ Yes ____ Comments:

DISCIPLINE: What forms of discipline do you use when correcting your child? Circle the form(s) that you think work best for your child and family:

Time Outs Grounding Loss of toy/privilege Spanking Praise
Contracts Rewards Other:

Who is the main disciplinarian in your home?

Is there any thing you want to write about the rules in your child's home(s) and how discipline occurs?
No ___ Yes ___ Comments:

FINANCIAL: Are there financial stresses affecting the family? No ____ Yes ____
Is anyone in the family on disability? No ____ Yes ____

ABUSE: Any concerns or history of abuse or neglect of the child? No ____ Yes ____

Abuse: Verbal _____ Physical _____ Sexual _____ Neglect: _____

If yes, indicate the alleged perpetrator & dates:

Was there any Child Protection Services involvement? No ____ Yes ____

CHILD LEGAL HISTORY: Arrests? No ___ Yes ___ Probation? No ___ Yes ____
If yes, list dates and charges:

LOSSES: Please list any significant deaths or losses. Include relatives, friends and pets. None ____

CHANGES: *Any other changes such as friends moving, changes in custody, parent's work hours, parent's health etc.?* No _____ Yes ____ *Comments:*

OTHER INFORMATION: Is there any other Information about your child or family, which you think would be helpful for us to know? None ____ Comments:

NAME OF PERSON(S) COMPLETING THIS FORM:_____

RELATIONSHIP TO CHILD/TEEN_____