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PSYCHOLOGIST

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**CHILD/ADOLESCENT HISTORY QUESTIONNAIRE**

The purpose of this questionnaire is to obtain an understanding of your life experience and background. Then we can begin to develop a comprehensive treatment program suited to your specific needs. Please return this questionnaire when completed, or at your scheduled appointment.

Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Circle: M / F

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_

By who were you referred?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chief Complaint:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What made you seek help at this time?

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Any previous mental health contact? Please explain.

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What changes would you like to see in your child?

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**PRESENTING PROBLEM:**

(check all that apply)

\_\_\_ Very Unhappy \_\_\_ Stubborn \_\_\_ Fire setting

\_\_\_ Irritable \_\_\_ Disobedient \_\_\_ Stealing

\_\_\_ Temper Outbursts \_\_\_ Infantile \_\_\_ Lying

\_\_\_ Withdrawn \_\_\_ Mean to others \_\_\_ Sexual trouble

\_\_\_ Daydreaming \_\_\_ Destructive \_\_\_ School Performance

\_\_\_ Fearful \_\_\_ Trouble with the law \_\_\_ Truancy

\_\_\_ Clumsy \_\_\_ Running away \_\_\_ Bed wetting

\_\_\_ Overactive \_\_\_ Self-mutilating \_\_\_ Soiled pants

\_\_\_ Slow \_\_\_ Head banging \_\_\_ Eating problems

\_\_\_ Short attention span \_\_\_ Shy \_\_\_ Sleeping problems

\_\_\_ Distractible \_\_\_ Rocking \_\_\_ Drug Use

\_\_\_ Lacks initiative \_\_\_ Strange behavior \_\_\_ Sickly

\_\_\_ Undependable \_\_\_ Strange thoughts \_\_\_ Alcohol Use

\_\_\_ Peer conflict \_\_\_ Phobic \_\_\_ Suicide talk

\_\_\_ Impulsive

Problems perceived to be:

\_\_\_ very serious \_\_\_ serious \_\_\_ not serious

How long have these problems occurred? (number of weeks, months, years) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PSYCHOSOCIAL HISTORY**

Who has authority to make medical decisions for this child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please bring a copy of any supporting documentation.)

If child is adopted, has he/she been told?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s religious/spiritual upbringing?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Status of Parents:**

MOTHER: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(please circle one) Natural parent Step-parent Adoptive parent Relative: \_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(please circle one) Married Divorced Remarried Separated Deceased Single

FATHER: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(please circle one) Natural parent Step-parent Adoptive parent Relative: \_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(please circle one) Married Divorced Remarried Separated Deceased Single

OTHER PRIMARY CARE GIVER: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_

(please circle one) Natural parent Step-parent Adoptive parent Relative: \_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(please circle one) Married Divorced Remarried Separated Deceased Single

OTHER PRIMARY CARE GIVER: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_

(please circle one) Natural parent Step-parent Adoptive parent Relative: \_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(please circle one) Married Divorced Remarried Separated Deceased Single

Please list anyone else living in the home (s):

|  |  |  |  |
| --- | --- | --- | --- |
| NAME | AGE | GENDER | RELATIONSHIP TO CHILD |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
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Number of moves in child’s life: \_\_\_\_\_\_\_

Dates and places:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Was the child ever placed, boarded, or lived away from the family?

\_\_\_ Yes \_\_\_ No If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Significant deaths or losses in the family:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of loss: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has this affected your child’s behavior? \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What are the major family stressors at the present time, if any?

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List all extended family members by their relation to the patient who have drug and/or alcohol problems (legal or illegal), history of depression, self-destructive behavior, or legal problems.

|  |  |  |
| --- | --- | --- |
| **NAME** | **PROBLEM** | **RELATION TO CHILD** |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |
|  |  |  |

Are there any family members with chronic or severe medical problems? If yes, please indicate relative and illness below.

|  |  |  |
| --- | --- | --- |
| **NAME** | **PROBLEM** | **RELATION TO CHILD** |
|  |  |  |
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**CHILD HEALTH INFORMATION**

Name of Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the child ever been hospitalized?

|  |  |
| --- | --- |
| **Age/duration** | **Problem/reason** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Has the child ever taken, or is he/she taking presently, any prescribed medications? \_\_ Yes \_\_No

If yes, please list name, dosage, and reason for medication:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child experienced any of the following? If yes, please explain.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Symptom** | **Yes** | **Age** | **Duration** | **Problem/reason** |
| Dental Problems |  |  |  |  |
| Weight Problems |  |  |  |  |
| Allergies |  |  |  |  |
| Skin Problems |  |  |  |  |
| Asthma |  |  |  |  |
| Headaches |  |  |  |  |
| Blood Pressure |  |  |  |  |
| Meningitis |  |  |  |  |
| Convulsions |  |  |  |  |
| Fainting |  |  |  |  |
| Sinus Problems |  |  |  |  |
| Vision Problems |  |  |  |  |
| Ear aches |  |  |  |  |
| Unconsciousness |  |  |  |  |
| Stomach Problems |  |  |  |  |
| Tonsils out |  |  |  |  |
| Hyperactivity |  |  |  |  |
| High Fevers |  |  |  |  |
| Pneumonia |  |  |  |  |
| Flu |  |  |  |  |
| Encephalitis |  |  |  |  |
| Concussions |  |  |  |  |
| Accident Prone |  |  |  |  |
| Anemia |  |  |  |  |
| Head Injury |  |  |  |  |
| Dizziness |  |  |  |  |
| Heart Problems |  |  |  |  |
| Hearing Problems |  |  |  |  |
| Other: |  |  |  |  |
| Other: |  |  |  |  |
| Other: |  |  |  |  |

Please list any allergies : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**DEVELOPMENTAL HISTORY**

Place of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was this child wanted? \_\_\_ Yes \_\_\_ No Planned for? \_\_\_ Yes \_\_\_ No

Normal Pregnancy? \_\_\_ Yes \_\_\_ No If no, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BIRTH**: Were there any complications during birth? \_\_\_ No \_\_\_Yes

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Did mother use alcohol or drugs during pregnancy? \_\_\_ No \_\_\_Yes

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**NEWBORN PERIOD**: Please circle any of the below issues you had with your child:

Vomiting Irritability Difficulty breathing Difficulty sleeping

Convulsions/twitching Colic Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DEVELOPMENTAL MILESTONES**: Were your child’s milestone’s met at appropriate ages?

If not, please explain below:

|  |  |  |
| --- | --- | --- |
| Age/duration | Problem/reason | Intervention received date(s) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**RELATIONSHIP TO SIBLINGS AND PEERS:**

\_\_\_ individual play \_\_\_ group play \_\_\_ cooperative \_\_\_ competitive \_\_\_ follower \_\_\_ leader

Describe special habits, fears, and idiosyncrasies of your child:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**EDUCATIONAL HISTORY**

What school does your child attend? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade? \_\_\_\_\_\_\_

Type of classes: \_\_\_ Mainstream \_\_\_ Special Education Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have an IEP? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child skip any grades? \_\_\_No \_\_\_Yes Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child repeat any grades? \_\_\_No \_\_\_Yes Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child attend school regularly? \_\_\_Yes \_\_\_No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been suspended or expelled? \_\_\_No \_\_\_Yes If yes, for what? \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Highest grade on last report card? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lowest? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Favorite subject? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Least favorite? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child appear motivated for school? \_\_\_ Yes \_\_\_ No

Does your child participate in extracurricular activities? \_\_\_ No \_\_\_ Yes If yes, please list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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In school, how many friends does your child have? \_\_\_ a lot \_\_\_ a few \_\_\_ none  
What are your child’s educational aspirations? \_\_\_ quit school \_\_\_ graduate high school

\_\_\_ college \_\_\_not age appropriate

List your child’s special interests, hobbies, or skills:

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Has your child ever been involved with the legal system? \_\_\_ No \_\_\_ Yes If yes, please explain:

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Has your child ever used any drugs or alcohol? \_\_\_ No \_\_\_Yes If yes, please indicate type and whether use is past or present.

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Has your child ever been employed? \_\_\_ No \_\_\_ Yes If yes, please list types of jobs/duration:

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Additional Comments:

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Signature of parent or guardian Date

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Signature of client if age 14 or older Date