Child and Adolescent Questionnaire

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Child's Name: ______________________ Today's Date: __________

DOB: __________ Age: __________ Grade in School: __________

HOME INFORMATION

List Siblings / Ages: ______________ / ____ ______________ / ____
______________ / ____ ______________ / ____

Child's Primary Address: ______________________

____

Who lives in household with child? ______________________

SCHOOL INFORMATION

School: ______________________ Phone: __________

Teacher(s): ______________________ 504 or IEP? __________

OT / Speech / Therapist: ______________________

CHILD'S MEDICAL INFORMATION

Child's PCP: ______________________ Phone: __________

Other Doctor(s): ______________________ Phone: __________

Therapist(s): ______________________ Phone: __________

Diagnoses (current/prior): ______________________

Medications/Doses: ______________________

Allergies: ______________________

PARENTAL INFORMATION

Parent Name: ______________________ Email: __________

Phone (H): ______________________ Phone (W): __________

Parent Name: ______________________ Email: __________

Phone (H): ______________________ Phone (W): __________

Describe the issue(s) that concern you with your child/adolescent/family.

What do the parents feel needs to change? (please check)

Behavior at School		School Effort / Grades	
Behavior at Home		School or School System	
Parent's Expectations		Child/Adolescent's Personality	
Teacher's Attitude		Other (describe below)	

What has each parent been doing about the problem at home? What has worked? What hasn't worked?

Please list all professionals and agencies involved with the family

Does the child/adolescent agree that there is a problem?

SCHOOL INFORMATION

What does the child/adolescent do well at school?

What does s/he do poorly at school?

Has the child/adolescent had any difficulty with school attendance? (describe)

Has the child/adolescent been held back in any grade? (describe)

Has there been psychological testing done at school?

Has the child/adolescent been in "special education" classes? (describe)

Does the child/adolescent have friends? No _____ A few _____ Many _____

Please rate how your child gets along with others, using the indicated scale:

Poorly 1 • 2 • 3 • 4 • 5 Well							
Peers		Siblings		Parents		Teachers	

MEDICAL INFORMATION:

Please check below to indicate your impression of your child/adolescent's development in the following areas:

Development	slow	average	fast
Physical			
Language			
Intellectual			
Social			
Emotional			

List any serious accidents, including age and type:

List all hospitalizations, operations, and serious illnesses, including age and type:

What medications is the child/adolescent taking?

Medication	Dosage	When Taking

LEGAL INFORMATION:

Has child/adolescent ever been in trouble with the law?

If yes, how many times? ______ Approximate dates: ______

Is the child/adolescent currently on probation? ______

If yes, who is the probation officer? ______ Phone: ______

Is there any legal action pending? ______

MENTAL HEALTH HISTORY

Previous Counselor	Dates	Reason(s)

SYMPTOM INFORMATION: Circle any of the following that you observe in your child/adolescent:

headaches	dizziness	stomach trouble	bowel trouble
back pain	tremors / tics	other physical problems	difficulty getting to sleep
nightmares	trouble concentrating	memory problems	worries a lot
can't make decisions	tense / unable to relax	panicky feelings	unreasonable fears
fear of losing control	strange/unusual thoughts	hallucinations	repetitive thoughts/acts
feels others try to harm him/her	aggressive outbursts	thoughts of harming someone	use of alcohol/drugs
wakes up too early / can't fall back to sleep	loss of appetite	weight loss	unable to enjoy life
feels worthless	feels hopeless	thoughts of suicide	no energy
sadness / depression	withdrawn from others	weight gain	increased energy
decreased need for sleep	family conflicts	work problems	can't make/keep friends
feels very shy	afraid to stand up for his/her rights	Other:	Other:

If using alcohol/drugs, what and how often?

List major changes/stressors the child/adolescent has experienced in the past few months

List major changes/stressors the child/adolescent has experienced in the past few years

List any significant health problems of the child and/or family

Identify any unusual or disturbing habits or behaviors displayed by the child/adolescent

Describe any common or recurring complaints or concerns by the child/adolescent

How would you describe your child's/adolescent's personality?

Which parent is the child most similar to? In what ways?

If appropriate, how stable is the marital relationship of the parents?

Each child often plays a certain role in the family. If you can, list each child and their role(s).

What is the family history regarding depression, suicide, or other emotional problems?

Has any member of the family had difficulty with the law? If so, please describe.

What are the child's tasks/chores in the household?

How are emotions such as anger and hurt expressed in the family?

How is discipline handled in the home?

Has any family member suffered a serious injury or illness? Please describe.

Family history. Please circle any item for which there is any family history

physical abuse	sexual abuse	developmental delay	attention deficit
hyperactivity	substance abuse	domestic violence	

Please write in the name of family member(s) who have (or had) problems with:					
eating		affection		memory	
sleeping		humor		physical health	
fantasizing		perfectionism		fighting	
learning problems		moodiness		defiance	
alcohol		impulse control		fearfulness	
bed-wetting		short attention		body image	
drugs		activity level		compulsive behavior	
sexuality		aggression		sibling rivalry	
anger		following rules		overly compliant	
unusual thoughts		responsibilities			