

HQGRWDE LJKWVSGEWH HQGRWDE LJKWV 1 2 3 IILFH D E F W V P Q R U J

History Questionnaire - Child or Adolescent

Please take time to fill out this form for your child.
This will aid greatly in providing appropriate therapeutic care for them.

Name of Child: _____ DOB: _____

BIRTH HISTORY

Pregnancy

Which of the mother's pregnancies was this? (1st, 2nd, etc.) _____

- Yes No Has the mother had any miscarriages
- Yes No Any previous premature babies?
- Length of pregnancy in weeks (most babies are born 38-42 weeks) _____
- Yes No Illness/Infection/Accident during pregnancy? Describe: _____
- Yes No Medication during pregnancy Describe: _____
- Yes No Was this a planned pregnancy? Describe: _____
- Yes No Depression/Stress during pregnancy? Describe: _____
- Yes No Alcohol use during pregnancy? Describe: _____
- Yes No Smoke cigarettes during pregnancy? Describe: _____
- Yes No Drug use during pregnancy? Describe: _____

Labor and Delivery

- Yes No Induced?
- Yes No Labor lasted more than 12 hours?
- Yes No C-Section? If yes, reason: _____
- Yes No Anesthesia? If yes, type: Spinal Epidural General (Asleep)
- Yes No Any complications with labor or delivery?

Describe if yes: _____

Birth Weight _____ lbs _____ oz

- Yes No Breastfed?
- How many days spent in the hospital? _____

Infancy

- Yes No Enjoyed cuddling? Yes No Fussy, Irritable
- Yes No More active than other babies? Yes No Sleeping difficulties
- Yes No Colic? Yes No Eating difficulties

Briefly describe your child as a toddler: _____

DEVELOPMENTAL HISTORY

As best you can recall, record the age at which your child reached the following developmental milestones. If you cannot recall, check the appropriate box.

Milestone:	Age:	Best recollection if exact age is not recalled:		
Sat without support	_____	<input type="checkbox"/> Early	<input type="checkbox"/> Normal	<input type="checkbox"/> Late
Crawled	_____	<input type="checkbox"/> Early	<input type="checkbox"/> Normal	<input type="checkbox"/> Late
Stood without support	_____	<input type="checkbox"/> Early	<input type="checkbox"/> Normal	<input type="checkbox"/> Late
Walked without assistance	_____	<input type="checkbox"/> Early	<input type="checkbox"/> Normal	<input type="checkbox"/> Late
Threw Ball	_____	<input type="checkbox"/> Early	<input type="checkbox"/> Normal	<input type="checkbox"/> Late
Spoke first words	_____	<input type="checkbox"/> Early	<input type="checkbox"/> Normal	<input type="checkbox"/> Late

(continued) Milestone: _____ Age: _____ Best recollection if exact age is not recalled: _____

Spoke phrases	_____	<input type="checkbox"/> Early	<input type="checkbox"/> Normal	<input type="checkbox"/> Late
Spoke sentences	_____	<input type="checkbox"/> Early	<input type="checkbox"/> Normal	<input type="checkbox"/> Late
Bowel trained	_____	<input type="checkbox"/> Early	<input type="checkbox"/> Normal	<input type="checkbox"/> Late
Bladder trained, day	_____	<input type="checkbox"/> Early	<input type="checkbox"/> Normal	<input type="checkbox"/> Late
Bladder trained, night	_____	<input type="checkbox"/> Early	<input type="checkbox"/> Normal	<input type="checkbox"/> Late
Tied shoelaces	_____	<input type="checkbox"/> Early	<input type="checkbox"/> Normal	<input type="checkbox"/> Late

List any childhood illnesses, serious accidents, or hospitalizations:

Age at time of incident:	Describe incident:
_____	_____
_____	_____
_____	_____
_____	_____

<input type="checkbox"/> Yes <input type="checkbox"/> No	History of head injury or loss of consciousness	Describe: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	History of seizures	Describe: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies	Describe: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Current health problems	Describe: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Current infectious disease(s)	Describe: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Current medications	Describe: _____
	Name of medications: _____	
	Dose/frequency: _____	

Additional comments: _____

Describe your child in the following areas:

Sleeping habits: _____

Eating habits: _____

Energy level: _____

Yes No Does your child or anyone living with you have an infectious disease?

If yes, what? _____

Current height of your child: _____ ft _____ inches Current weight of your child: _____ lbs

Yes No Does your child have any health related problems?

If yes, explain: _____

Parents' current marital status:

<input type="checkbox"/> Married to each other for _____ years	<input type="checkbox"/> Mother involved with someone
<input type="checkbox"/> Separated for _____ years	<input type="checkbox"/> Father involved with someone
<input type="checkbox"/> Divorced for _____ years	<input type="checkbox"/> Mother deceased for _____ years
<input type="checkbox"/> Mother remarried _____ times	Child's age at time of mother's death: _____
<input type="checkbox"/> Father remarried _____ times	<input type="checkbox"/> Father deceased for _____ years
	Child's age at time of father's death: _____

List any other people living in your home at this time:

Name: _____ Age: _____ Relationship to child: _____
 Name: _____ Age: _____ Relationship to child: _____
 Name: _____ Age: _____ Relationship to child: _____
 Name: _____ Age: _____ Relationship to child: _____
 Name: _____ Age: _____ Relationship to child: _____
 Name: _____ Age: _____ Relationship to child: _____

List other important family members or relatives living outside the home:

Name: _____ Age: _____ Relationship to child: _____
 Name: _____ Age: _____ Relationship to child: _____
 Name: _____ Age: _____ Relationship to child: _____
 Name: _____ Age: _____ Relationship to child: _____
 Name: _____ Age: _____ Relationship to child: _____

Which of the following describes your child's current living situation?

- Rent apartment Rent house Own house
 Foster care Condominium Shelter
 Homeless Group home Residential treatment

What is the primary language spoken in your home? _____

Mother's current employer/job title: _____

Father's current employer/job title: _____

FAMILY HISTORY

List the places your child has lived since birth, the dates they lived there, and with whom:

Where:	With whom:	Dates (from-to):
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____

Have your child ever experienced any of the following?

- Yes No Physical Abuse Age/Describe: _____
 Yes No Sexual Abuse Age/Describe: _____
 Yes No Assault Age/Describe: _____
 Yes No Death of a parent Age/Describe: _____
 Yes No Death of a relative Age/Describe: _____
 Yes No Death of a friend Age/Describe: _____
 Yes No Parental separation Age/Describe: _____

FAMILY HISTORY

Please describe on both parents' side of the family any history of mental illness, suicide, legal problems, chemical abuse or dependency and physical/sexual abuse.

If it is someone else, describe his or her relationship to you (i.e. paternal uncle- alcoholic, mother- depression, etc):

Mother's side of the family:

- Yes No Alcohol abuse If yes, whom? _____
 Yes No Substance abuse If yes, whom? _____
 Yes No Mental Health problems If yes, whom? _____
 Yes No Physical abuse If yes, whom? _____

Yes No Sexual abuse whom? _____
If yes, whom? _____

Father's side of the family:

Yes No Alcohol abuse If yes, whom? _____
 Yes No Substance abuse If yes, whom? _____
 Yes No Mental Health problems If yes, whom? _____
 Yes No Physical abuse If yes, whom? _____
 Yes No Sexual abuse If yes, whom? _____

Other issues currently affecting family members:

Yes No Health problems If yes, describe: _____
 Yes No Disabilities If yes, describe: _____
 Yes No Legal issues If yes, describe: _____
 Yes No Financial concerns If yes, describe: _____

CHEMICAL HEALTH

Are you aware of or do you suspect any chemical use by your child?

Yes No Cigarettes Describe: _____
 Yes No Alcohol Describe: _____
 Yes No Marijuana Describe: _____
 Yes No Inhalants Describe: _____
 Yes No Methamphetamines Describe: _____
 Yes No Cocaine/Crack Describe: _____
 Yes No Acid/LSD Describe: _____
 Yes No Other Describe: _____
 Yes No Previous chemical use problems Describe: _____
 Yes No Has your child ever had any chemical assessment done? If yes, when? _____
 Yes No Has your child ever had chemical dependency treatment? If yes, when? _____

Describe the parental use of drugs or alcohol at this time:

MOTHER

Yes No Cigarettes Describe: _____
 Yes No Alcohol Describe: _____
 Yes No Marijuana Describe: _____
 Yes No Inhalants Describe: _____
 Yes No Methamphetamines Describe: _____
 Yes No Cocaine/Crack Describe: _____
 Yes No Acid/LSD Describe: _____
 Yes No Other Describe: _____
 Yes No Previous chemical use problems Describe: _____
 Yes No Previous chemical dependency treatment: Describe: _____

FATHER

Yes No Cigarettes Describe: _____
 Yes No Alcohol Describe: _____
 Yes No Marijuana Describe: _____
 Yes No Inhalants Describe: _____

- Yes No Methamphetamines Describe: _____
- Yes No Cocaine/Crack Describe: _____
- Yes No Acid/LSD Describe: _____
- Yes No Other Describe: _____
- Yes No Previous chemical use problems Describe: _____
- Yes No Previous chemical dependency treatment: Describe: _____

SCHOOL

Name of the school your child attends: _____ Grade: _____

Teacher/case manager: _____

- Yes No Do you feel the school meets your child's needs?
 - Yes No Do you have regular contact with their teachers?
 - Yes No Is your child receiving special education services?
 - Yes No Was your child ever retained a grade?
 - Yes No Does your child participate in extracurricular activities at school?
 - Yes No Does your child struggle academically at school?
 - Yes No Does your child have behavior problems at school?
 - Yes No Has your child ever been suspended or expelled from school?
 - Yes No Does your child miss school regularly?
- How many days of school has your child missed this school year? _____
- How many days of school did your child miss the previous year? _____
- Highest educational level reached by parents: _____ Mother: _____
- Father: _____

SUPPORTIVE FACTORS

List any previous mental health services your child has received:

Clinic Name:	Therapist Name:	Dates:	Was it helpful?
1 _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2 _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3 _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
4 _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

- Yes No Does your child have a probation officer?
- Yes No Does your child have a County Social Worker?
- Yes No Does your child have a Guardian ad Litem (GAL)?
- Yes No Does your child have any other service providers?

Describe: _____

Yes No Has your child ever been placed outside the home?

Where:	Dates:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Who are the people or services that you find supportive to you and your family (i.e. church, relatives)? Please be specific.

Describe the role of religious and/or spiritual influences on your family:

Describe any extracurricular activities you have or recreational hobbies you participate in:

Please check any areas that you may be concerned about:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Crying a lot | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Obsessive Thoughts |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Running away from home | <input type="checkbox"/> Obsessive Behaviors |
| <input type="checkbox"/> Not Following Rules | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Excessive Worrying | <input type="checkbox"/> Gender Confusion |
| <input type="checkbox"/> Bedwetting/Soiling | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Strange Behaviors | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Learning Difficulties | <input type="checkbox"/> Promiscuity | <input type="checkbox"/> Suicidal thoughts/plans | <input type="checkbox"/> Odd beliefs |
| <input type="checkbox"/> Truancy | <input type="checkbox"/> Chemical Use | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Perfectionist |
| <input type="checkbox"/> Fighting | <input type="checkbox"/> Lack of Friends | <input type="checkbox"/> Avoid Others | <input type="checkbox"/> Gang Involvement |
| <input type="checkbox"/> Stealing | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Self Injurious Behavior | <input type="checkbox"/> Mood Changes |
| <input type="checkbox"/> Fire Setting | <input type="checkbox"/> Violent | <input type="checkbox"/> Vandalism | <input type="checkbox"/> Doesn't Pay Attention |
| <input type="checkbox"/> Hot Temper | <input type="checkbox"/> Destroys Things | <input type="checkbox"/> Physical problems with no known medical cause | |

Please elaborate about anything you mentioned above that you are concerned about/any other stressors you are dealing with:

YOUR CHILD'S STRENGTHS (Check all that apply)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Stays Active | <input type="checkbox"/> Employed | <input type="checkbox"/> Attend school/Work Regularly | <input type="checkbox"/> Cope with problems well |
| <input type="checkbox"/> Independent | <input type="checkbox"/> Positive Outlook | <input type="checkbox"/> Spiritual | <input type="checkbox"/> Humorous |
| <input type="checkbox"/> Helpful | <input type="checkbox"/> Easy Going | <input type="checkbox"/> Intelligent | <input type="checkbox"/> Caring |
| <input type="checkbox"/> Share with Others | <input type="checkbox"/> Maintain Friends | <input type="checkbox"/> Liked By Peers | <input type="checkbox"/> Playful |
| <input type="checkbox"/> Good Looking | <input type="checkbox"/> A Leader | <input type="checkbox"/> Has a hobby | <input type="checkbox"/> Artistic |
| <input type="checkbox"/> Athletic | <input type="checkbox"/> Liked by Others | <input type="checkbox"/> Structure Time Well | <input type="checkbox"/> Responsible |
| <input type="checkbox"/> Structures Time Well | <input type="checkbox"/> Responsible | <input type="checkbox"/> Good Health | <input type="checkbox"/> Positive view of the world |
| <input type="checkbox"/> Liked by Adults | <input type="checkbox"/> Tells you where they are | <input type="checkbox"/> Gets Along with Siblings | <input type="checkbox"/> Does Homework |
| <input type="checkbox"/> Gets Along with Parents | <input type="checkbox"/> Volunteers | <input type="checkbox"/> Involved with Positive Adults | |
- Others _____

FAMILY STRENGTHS (Check all that apply)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Parents Employed | <input type="checkbox"/> Go on Vacations Together | <input type="checkbox"/> Often Eat Supper Together | <input type="checkbox"/> Attend Church |
| <input type="checkbox"/> Clear Rules at Home | <input type="checkbox"/> Relatives Involved with Child | <input type="checkbox"/> Do Activities Together | <input type="checkbox"/> Caring |
| <input type="checkbox"/> Sense of Humor | <input type="checkbox"/> Good Support Network | <input type="checkbox"/> Involved at Child's School | <input type="checkbox"/> Resilient |
| <input type="checkbox"/> Knows Child's Friends | <input type="checkbox"/> Volunteer in Community | <input type="checkbox"/> Help Children with Problems | <input type="checkbox"/> Good Communication |
| <input type="checkbox"/> Consistent Parenting | <input type="checkbox"/> Parents Get Along | <input type="checkbox"/> Know Parents of Child's Friends | <input type="checkbox"/> Able to Show Affection |
| <input type="checkbox"/> Know How Child is Doing at School | <input type="checkbox"/> Strong Ethnic/Cultural Identity | <input type="checkbox"/> Children have Jobs in the Home | |
- Others _____

What would you like to see come out of services for your child?

Is there any other information that would be helpful to know in helping your child?

COMPLETED BY: _____

DATE: _____

Relationship to child: _____