CHILD\ADOLESCENT HISTORY QUESTIONAIRE

Your Child\Adolescent's Name_____ Today's Date_____

Please fill out the grid below and those questions following. Please do not skip sections. It is important that I get a complete history.

1 Not a Problem	**2** A Mild Problem	**3** A Moderate Problem	**4** A Serious Problem

CHILD'S PHYSICAL FUNCTIONS		CHILD'S SCHOOL EXPERIENCE	
Sleep too much	**1 2 3 4**	Failing Grades\Grades do match Abilities	**1 2 3 4**
Can't get to sleep or stay asleep	**1 2 3 4**	Does not follow Rules at School	**1 2 3 4**
Appetite changed	**1 2 3 4**	Handling School related Stress	**1 2 3 4**
Weight Gain	**1 2 3 4**	Absent\Tardy often	**1 2 3 4**
Weight Loss	**1 2 3 4**	Difficulty making Friends	**1 2 3 4**
Bladder or Bowel Control	**1 2 3 4**	Difficulty paying attention in class	**1 2 3 4**
Fatigue/Lack of Energy	**1 2 3 4**		
CHILD'S INNER THOUGHTS		PROBLEM AREAS	
Trouble Concentrating	**1 2 3 4**	Problems with Parents Divorcing	**1 2 3 4**
Memory Problems	**1 2 3 4**	Dealing with someone else's alcohol\drug use	**1 2 3 4**
Thoughts of Hurting Self	**1 2 3 4**	Death of a loved one	**1 2 3 4**
Thoughts of Hurting Others	**1 2 3 4**	History of Sexual Abuse	**1 2 3 4**
Excessive Worries	**1 2 3 4**	Having health problems	**1 2 3 4**
Worried about Gaining too much weight	**1 2 3 4**	Family Violence (actual or threatened)	**1 2 3 4**
		History of Physical Abuse	**1 2 3 4**
CHILD'S FEELINGS AND MOODS		Don't get along with Parents	**1 2 3 4**
Depressed/Sad a lot	**1 2 3 4**		
Frequent Crying	**1 2 3 4**	CHILD'S BEHAVIOR	
Feeling Angry Often	**1 2 3 4**	Does not follow rules at home	**1 2 3 4**
Irritability	**1 2 3 4**	Violent toward others	**1 2 3 4**
Doesn't Like Self	**1 2 3 4**	Stay to yourself most of the time	**1 2 3 4**
Sudden Change in Moods	**1 2 3 4**	Attempted to hurt self	**1 2 3 4**
Anxiety/nervousness	**1 2 3 4**	Over use of drugs\alcohol	**1 2 3 4**
Becomes easily Frustrated	**1 2 3 4**		
Feels Lonely	**1 2 3 4**		
No longer enjoy things you used to enjoy	**1 2 3 4**		

What is the primary problem that has brought your child to counseling?

Please list the goals you hope to achieve in counseling (Be specific).

Have you been in therapy before?_____ When?_____ Was it helpful?_____

Names of Prior Mental Health\Chemical Dependency Providers: _____

Current Medications	Dosages	Started When?	For What Condition?	Prescribed By?

Primary Physician's Name: _____Practice Name: _____Phone #: _____

Is your child\adolescent currently under the care of a physician and for what: _____
_____

Last Exam? _____

Please list additional medical conditions, past and present: _____

Does your child have or had any seizures or is diabetic? _____

Please list any alcohol\drugs your child\adolescent is using\abusing _____

Has your child\adolescent ever had a head injury (either lost consciousness or did not lose consciousness)?_____

Religious Affiliation:_____
Religion's importance to you and your child\adolescent: □ Not at all □ Somewhat □ Very

List any family history of problems with mental health or chemical dependence_____
_____

MOTHER'S PREGNANCY WITH THIS CHILD: Age at time of pregnancy _____ Planned?_____
Complications? _____
Alcohol\drug consumption during pregnancy?_____ How much? _____Frequency _____
Medications taken during pregnancy? _____Duration of pregnancy (weeks) _____
Delivery: Complications ? _____
Post Delivery: Number of days in the hospital\special care nursery? _____ Postpartum Blues? _____

DEVELOPMENTAL MILESTONES: Please write in approximate age achieved

Began Crawling _____ Began Walking_____ Said several words besides mama, dada _____
Slept Through the night_____ Achieved Bladder Control _____ Achieved Bowel Control _____

Describe your child\adolescent's early temperament _____
and current temperament _____

Describe your child\adolescent's attachment to mother _____ father _____

MEDICAL HISTORY: Note age of occurrence and other pertinent information:

Childhood Diseases _____ NONE □
Operations\Hospitalizations _____ NONE □
Head Injuries (with or without losing consciousness) _____ NONE □
Convulsions _____ NONE □
Persistent high Fevers _____NONE □
Eye Problems _____ NONE □
Ear Problems _____ NONE □
Allergies or Asthma _____NONE □
Poisoning _____ NONE □

Please provide any other information you feel is important: _____

_____

_____

THANK YOU FOR BEING THOROUGH!