CHILD/ADOLESCENT HISTORY QUESTIONAIRE

Your Child/Adolescent's Name_____ Today's Date_____

Please circle the number that best represents your concern. 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/ADOL PHYSICAL FUNCTIONS		CHILD/ADOL SCHOOL EXPERIENCE	
Sleep too much	1 2 3 4	Failing Grades/Grades Don't 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	Relating to Teacher is Difficult	1 2 3 4
CHILD/ADOL 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
		Don't Get Along with parents	1 2 3 4
CHILD/ADOL FEELINGS AND MOODS			
Depressed/Sad a lot	1 2 3 4	CHILD/ADOL BEHAVIOR	
Frequent Crying	1 2 3 4	Lying	1 2 3 4
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	Keep to themselves 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	Difficulty with Daily Routine	1 2 3 4
Becomes easily Frustrated	1 2 3 4	Do not have friends who are supportive	1 2 3 4
Feels Lonely	1 2 3 4	Using alcohol\drugs to cope with problems	1 2 3 4
No longer enjoy things you used to enjoy	1 2 3 4	Suicidal Actions	1 2 3 4
Hopelessness	1 2 3 4	Repeating certain acts over and over again	1 2 3 4
Euphoria (feeling "high", lots of energy)	1 2 3 4	Hyperactivity (can't sit still)	1 2 3 4
Worthlessness	1 2 3 4	Stealing	1 2 3 4
Lack of Energy	1 2 3 4	Dependency (relying on others to make decisions)	1 2 3 4

What is the primary problem that has brought your Child/Adolescent to counseling?

Please list goals you hope to achieve in counseling. (Be Specific) _____

_____

_____

Has your Child/Adol 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/Adol currently under the care of a physician and for what: _____

Last Exam? _____ Please list additional medical conditions, past and present: _____

Does your Child/Adol ever had or have seizures or have diabetes's? _____Please list any supplements, vitamins or other non-prescription aids they are taking_____

Has your Child/Adol ever had a head injury (either losing or not losing consciousness)? _____

Religious Affiliation: _____

Religion's importance to you: □ Not at all □ Some what □ Very

List any family history of Mental Health and Chemical Dependency: _____

_____

MOTHER'S PREGNANCY WITH THIS CHILD/ADOL: Age at the 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/Adol early temperament _____
And current temperament _____

Describe your Child/Adol Attachment to mother _____ to 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.