Child History Questionnaire

Please complete with information about your minor child entering treatment.

The following information is used to best determine a treatment plan. Completing this form as fully and accurately as possible will help facilitate this process. Please write all answers legibly. If you need additional space for any of your answers, please use the space at the end of this form. If you feel uncomfortable revealing some of the requested information, feel free to put an "X" through those sections.

Child's Personal Data

Name:_____ Date:_____

Age:_____ Gender (M/F):_____ SSN:_____

Where was your child born?_____

Where has your child spent most of his/her life?_____

What is your child's current living environment? (house, apartment):_____

How satisfied are you with your current living environment?_____

Who does your child live with? (list people and relationship to child) _____
_____

Child's Family History

Father

Name: _____ Age:_____

If deceased, cause of death: _____ Child's age at that time:_____

Father's Occupation: _____

Father's Health: _____

Briefly describe father's personality and his attitude toward child (past & present):

_____

_____

Mother

Name: _____ Age:_____

If deceased, cause of death: _____ Child's age at that time:_____

Mother's Occupation: _____

Mother's Health: _____

Briefly describe child's mother's personality and her attitude toward child (past & present):

_____

How would you describe your child's cultural identity?_____
How would you describe your child's religious or spiritual identity?_____

Siblings

Provide ages, marital status, and occupations: _____

_____

_____

_____

Briefly describe child's relationship with siblings: _____

_____

_____

Briefly describe child's home atmosphere (compatibility with parents, between parents and children, and between siblings): _____

_____

_____

Was child adopted? _____ If yes, at what age? _____ If yes, do you know anything about child's biological parents?_____

Are child's parents divorced? _____ If yes, what age was child when this occurred? _____

How did child feel about it? _____

If child has a step-parent or step-parents, give child's age when parent(s) remarried: _____
_____

If child is not being raised by parents, who is child's primary caregiver and between what ages:
_____
_____

Are there any fearful or distressing experiences regarding child's family life which stand out in your or child's mind which were not previously mentioned? (briefly describe) _____
_____
_____

Relationship History

Does your child have any children of his/her own? If yes, please list ages.
_____
_____

Does your child have people outside of your biological family and relatives that you feel are close friends or who are "like family" and in whom your child can confide?
_____
_____
_____

Educational/Occupational History

Years of education: _____ Degrees (GED, HS Diploma, B.A., etc.) _____

How are child's grades in school? _____ Any special education?_____

Any discipline problems in school?_____ Currently in school? _____

Is child currently working? If yes, where and how many hours per week?_____
Months/Years in this position: _____

How satisfied is child with current work situation? _____

Briefly describe child's work history and reasons for leaving any previous jobs:

_____

_____

_____

Medical History

List any current medical conditions:

_____

_____

_____

List any allergies:

_____

_____

List all medications child is currently taking, including dosages and the dates of initial prescriptions, and the prescribing physician:

Medication Dosage Initial Rx Date Prescribing Physician

_____

_____

_____

_____

List a history of mental health medication child has taken in the past and the dates used:

_____

_____

Is child presently under the care of a physician? _____ If so, list name, address and phone number:

_____

When was child's last complete physical exam? _____

Any difficulties during pregnancy? _____

Any drugs or alcohol used during pregnancy? _____

Was child born prematurely? _____

Briefly describe and significant information about child's development:_____

_____

_____

_____

Alcohol/Substance Use History

Does child drink caffeine currently? _____ If yes, describe typical consumption: _____
_____

Does child use tobacco currently? _____ If yes, please describe type and typical amount of use:
_____
If no, did child use it in the past? _____

Does child currently drink alcohol? _____ If yes, please describe, type, frequency, and typical amount of consumption: _____
_____

Does child currently use any recreational drugs? _____ If yes, please describe type, frequency, and typical amount of consumption: _____
_____
_____
_____

Has child formerly consumed alcohol or drugs to a greater extent than currently? _____
If yes, please describe: _____
_____
_____

Has child ever been in a drug or alcohol treatment program? _____ If yes, please list:
Dates Where Inpatient or Outpatient Outcome
_____
_____
_____

Mental Health History

Has child ever received psychological or psychiatric treatment/counseling before? _____
If yes, please provide the following information:
Dates of care Mental Health provider Purpose Outcome
_____
_____
_____

Has child ever been hospitalized for a psychiatric/emotional reason? _____
If yes, please provide the following information:

Dates	Hospital	Reason	Outcome

_____
_____
_____

Has child ever contemplated or attempted suicide? _____ If yes, please describe:

_____
_____

Has child ever contemplated or inflicted physical violence on another person? _____
If yes, please describe: _____
List any family history of mental health and/or substance abuse problems. List the relationship (father, sister, aunt, etc.) followed by the problem:

_____
_____
_____
_____

Present Concerns

Please briefly describe your reasons for seeking treatment for your child at this time:

_____
_____
_____
_____

How have these concerns evolved over time?

_____
_____
_____

Please check any of the following feelings or symptoms that apply to your child:

__Depressed
__Feel inferior
__Hopelessness
__Crying spells
__Mood swings
__Poor concentration
__Poor memory
__Low energy
__Feel detached
__Poor appetite
__Food binging
__Food purging
__Angry or irritable
__Guilt
__Difficulty making decisions
__Unable to relax

__Anxious
__Specific fears
__Panic attacks
__Sleep problems
__Sleeping more than usual
__Relationship problems
__Attention Deficit
__Soiling pants
__Law breaking behaviors
__Unable to enjoy myself
__Lack of interest in pleasant activities
__Sexual problems
__Memory lapses
__Fearing a loss of control
__Thoughts of harming or killing myself
__Bed wetting
__Truancy
__Nightmares

Please describe how you would like your child's life to be different when child is done with therapy:

_____
_____
_____
_____
_____

Is there any other information you think I should know prior to our beginning to work together?

_____
_____
_____
_____
_____