CHILD-ADOLESCENT QUESTIONNAIRE - TO BE FILLED OUT BY PARENT/GUARDIAN

The information you give in this questionnaire is strictly confidential and part of the assessment process. Please fill it out as thoroughly as possible.

The following questions are asked so that we can best understand your child. Please read the questions carefully and answer them as fully as possible. If there are any question you don't understand, they can be filled out with the therapist's help when you review the history together.

Child's Information

Child's name:_____ Birth Date:_____ Age:_____

Home Address:_____

Home Phone:_____ Cell (1):_____ Cell (2):_____

Child's Doctor:_____ Phone:_____

What are the concerns that caused you to seek help for your child and when did you notice?_____

_____

Please check all that apply:

☐ appears sad	☐ socially withdrawn	☐ feels hopeless
☐ depressed	☐ feeling worthless	☐ easily irritated
☐ lost interest in previously enjoyed activities	☐ low self-esteem	☐ fatigue
☐ oversleeping or insomnia	☐ overeating or appetite loss	☐ low energy
☐ aches, pains, stomach aches	☐ thoughts of suicide	☐ self-injury
☐ elevated mood	☐ more talkative than usual	☐ racing thoughts
☐ does things without thinking of consequences	☐ mood swings	
☐ anxiety	☐ racing heart	☐ difficulty breathing
☐ feelings of panic	☐ fearful	☐ anxious in social situations
☐ has been exposed to traumatic event/s	☐ obsessive behaviors	☐ excessive worry
☐ nightmares	☐ anxious when away from loved ones	☐ phobia of _____

Please check all that apply:

☐ fails to pay attention to details	☐ doesn't seem to listen	☐ easily distracted when spoken to
☐ difficulty following through on tasks	☐ disorganized	☐ fidgety
☐ overactive	☐ always "on the go"	☐ impulsive
☐ excessive gaming, internet use	☐ other toileting issues	☐ bedwetting
☐ eating problems	☐ poor body image	☐ gender image issues
☐ strange behavior	☐ head banging	☐ hears voices
☐ hair pulling	☐ unable to sleep alone	
☐ defiant	☐ argues with adults	☐ destructive
☐ cruel to animals	☐ fire setting	☐ stealing
☐ lying	☐ refuses to attend school	☐ running away
☐ views pornography	☐ drug use	☐ involvement with the police
☐ repetitive motor behavior (e.g. hand flapping)	☐ difficulty reading social cues	☐ poor social skills
☐ lacks friends	☐ bullying	☐ being bullied
☐ physically abused	☐ sexually abused	
☐ school performance problems	☐ struggles with reading	☐ struggles with math
☐ struggles with writing	☐ struggles with language	☐ delayed motor skill
☐ learning problem	☐ hearing problems	☐ visual problems
☐ sensory issues		

☐ Other:_____

_____

_____

Family History

Child lives with: _____

Is your child adopted? ☐ Yes ☐ No If yes, child's age at adoption: _____

When and how did the child learn about his or her adoption? _____

_____

Parent/Guardian	**Parent/Guardian**
Name _____	Name _____
Birth Date _____	Birth Date _____
Highest grade completed _____	Highest grade completed _____
Diploma/degree _____	Diploma/degree _____
Occupation _____	Occupation _____

Please describe if parent/guardian had any special education or experienced any challenges learning:

_____ _____

_____ _____

Please describe if parent/guardian has had any psychological or emotional concerns *(i.e. depression, anxiety, ADHD, substance use)*:

_____ _____

_____ _____

What support and help has parent/guardian received? (I.e., *medication, therapy, hospitalization, community services)*

_____ _____

_____ _____

Please describe if other family members *(or if child is adopted, and if known, if biological parents)* have/has had any learning difficulties:

_____

_____

Please describe if other family members *(or if child is adopted, and if known, if biological parents)* have/has had any psychological or emotional concerns: _____

_____

Did the family member/s received support and help *(i.e., medication, therapy, hospitalization, community services)*? ☐ Yes ☐ No
Please explain: _____

Please provide any other information about the child's extended family that might help your counselor understand your child's needs *(e.g., medical, developmental, behavioral, educational, emotional, or psychological):* _____

_____

_____

Has DCFS ever been involved with your family? ☐ Yes ☐ No
If yes, please explain: _____

_____

Please provide information about cultural heritage:

_____

_____

Please provide information about religious/spiritual background:

_____

_____

Family Relationships

Please describe your child's relationships with parents/guardians:

_____

_____

If your child has siblings, half- or step-siblings, please describe your child's relationships with them:

_____

_____

Do you have any pets? ☐ Yes ☐ No
If yes, please comment on how your child relates to the pet/s: _____

_____

Does your child have chores? ☐ Yes ☐ No
If yes, please describe: _____

Does your child get an allowance? ☐ Yes ☐ No
If yes, please describe: _____

Please describe your parenting style and how parents/guardians work together (i.e., similarities, differences, degree of ease):

_____

_____

Do you have rules in your house about the use of electronics *(i.e., use of computer, I-pad, cell phone, etc.)*? ☐ Yes ☐ No
If yes, please describe: _____

Do you monitor your child's use of the computer and games? ☐ Yes ☐ No
If yes, please explain: _____

Birth and Developmental History

Pregnancy was: ☐ Healthy, no concerns ☐ Complications
If complications, please explain: _____

Did you receive fertility treatment? ☐Yes ☐ No
If yes, please explain: _____

Was the mother taking any medication, drugs, or consuming alcohol at the time of conception? ☐ Yes ☐ No

Was the father taking any medication, drugs, or consuming alcohol at the time of conception? ☐ Yes ☐ No

If yes, please check all that apply:

Mother	Father
☐ Cigarettes- How many & frequency? _____	☐ Cigarettes- How many & frequency? _____
☐ Alcohol- How many & frequency? _____	☐ Alcohol- How many & frequency? _____
☐ Drugs- which drugs and frequency? _____	☐ Drugs- which drugs and frequency? _____

Labor and Delivery

Pregnancy length: ☐ Full-term ☐ Pre-mature; if pre-mature, how early: _____

Was the birth "normal?" ☐ Yes ☐ No
If yes, please explain: _____

Perinatal History

Birth Weight _____ Length _____ Apgar Scores (if known) _____

Did the mother or baby stay in Special or Intensive Care? ☐ Yes ☐ No
If yes, please explain: _____

Please list any complications at birth: _____

Infancy and Early Childhood

Please rate your child **(up to 4 years of age)** on the following behaviors. Circle 1 if the behavior on the left was present the majority of the time. Circle 5 if the behavior on the right was present the majority of the time. Stages in between are represented by 2, 3, or 4. If there are two behaviors listed, please check the one that was present.

Quiet and content	1	2	3	4	5	Colicky and irritable
Very easy to feed	1	2	3	4	5	Daily feeding problems
Slept well	1	2	3	4	5	Frequent sleeping problems
Usually relaxed	1	2	3	4	5	Often restless
Underactive	1	2	3	4	5	Overactive
Cuddly, easy to hold	1	2	3	4	5	Did not enjoy cuddling
Easily calmed down	1	2	3	4	5	☐ Tantrums ☐ Head banging
Cautious and careful	1	2	3	4	5	☐ Accident prone ☐ Daredevil
Coordinated	1	2	3	4	5	Uncoordinated
Enjoyed eye contact	1	2	3	4	5	Avoided eye contact
Liked people	1	2	3	4	5	Disliked contact with people
Separates from parents easily	1	2	3	4	5	Separation from parent with difficulty

Other concerns or comments regarding infancy and early childhood development: _____

_____

Did any event, health conditions, or separation disturb early infant-parent/guardian bonding or the developing toddler-mother relationship? ☐ Yes ☐ No

If yes, please explain: _____

_____

Ages at milestones:

Gross Motor:	Crawled _____		Language Skill:	Used single words_____
	Walked alone _____			Used 2 or more words _____
	Ran well _____			Describes activity _____
Fine Motor:	Fed self with spoon _____		Social/Adaptive Skill:	Potty trained/day: _____
	Scribbled _____			Potty trained/night _____
	Tied shoe _____			Parallel plays with peer_____

Medical History

My child's health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Please explain any concerns:_____

When was your child's last physical exam and results?_____

_____

Does your child have any allergies? ☐Yes ☐ No If yes, please list:_____

_____

Has your child been to the emergency room with a serious emergency, hospitalized, or had outpatient surgery? ☐ Yes ☐ No
If yes, please describe the condition/injury and treatment (e.g., surgery, when, how long, and where):_____

_____

If your child had a head injury, did he or she lose consciousness? ☐ Yes ☐ No If yes, how long?_____

How well does your child seem to be able to control behavior and attention? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please explain any concerns: _____

_____

Has your child had a hearing test? ☐ Yes ☐ No Date of exam: _____ Results:_____

Has your child had a vision screen? ☐ Yes ☐ No Date of exam: _____ Results:_____

Please list any medications your child currently takes including over-the-counter medicine *(with dose, frequency and time):*

_____

_____

Behavioral and Mental Health History

Please describe any behaviors that are concerning to you or others:

Please list any events in your child's life that you think may have had an impact on his/her development or current functioning. This could include situations or losses that are unusual, traumatic, or possible stressful: *(Please include child's age at the time and incident.)*

Has your child received support through counseling such as individual or family therapy, or group counseling? ☐Yes ☐ No
If yes, please explain:

Has your child received support through psychiatric hospitalization (day, partial, outpatient or inpatient)? ☐Yes ☐ No
If yes, please explain:

Safety Concerns

Has your child made statements of wanting to die or had thoughts, plans or attempted to hurt or kill him or herself? ☐ Yes ☐ No
If yes, please explain:

Has your child hurt themselves on purpose? ☐ Yes ☐ No
If yes, please explain:

Has your child acted impulsively *(e.g., running in the street or a parking lot, etc.)*? ☐ Yes ☐ No
If yes, please explain:

Has your child been aggressive or made threats of hurt others or property? ☐ Yes ☐ No
If yes, please explain:

Do you have weapons in your home? ☐ Yes ☐ No
If yes, are they secured and inaccessible to the children in the home? ☐ Yes ☐No

Social History

Please describe your child's personality:

Please describe your child's relationship with peers:

Please describe your child's extracurricular activities and/or use of free time:

Educational History

Did/does your child attend preschool or daycare? ☐ Yes ☐ No
If yes, describe the type of program, days of week, and age started: _____

_____

Current grade and school: _____

List previous schools and grades attended at each: _____

_____

Briefly describe your child's performance in school over time and strengths and concerns:

_____

_____

Is your child in a gifted program? ☐ Yes ☐ No Please describe:_____

Is your child in special education? ☐ Yes ☐ No Does your child have an IEP or 504 plan? ☐ Yes ☐ No
If yes, please explain:_____

Please describe if your child has a learning disability or language disorder or receives tutoring:

_____

Please identify your child's strengths:

_____

Please identify your family's strengths:

_____

What are your expectations of therapy?

_____

_____

Therapist Comments:

_____

_____

_____

_____

THANK YOU FOR YOUR TIME