CHILD/ADOLESCENT CLINICAL QUESTIONNAIRE

IDENTIFYING INFORMATION Date of Assessment: _____

Name of Child _____ Sex (M) _____ (F) _____

Date of Birth _____ Place of Birth _____ Age _____

Address _____

City _____ State _____ Zip Code _____

Home Phone ( ) _____ Cell Phone ( )_____

Religion (optional) _____ Education (grade) _____

Do you have anything you'd like us to know regarding religious practice, cultural, or gender identity?

_____

_____

Present school _____ Referral Source _____

CHIEF COMPLAINT:

Presenting Problems (check all that apply)

____ Very unhappy
____ Irritable
____ Temper outbursts
____ Withdrawn
____ Daydreaming
____ Fearful
____ Clumsy
____ Overactive
____ Slow
____ Short attention span
____ Distractible
____ Lacks initiative
____ Undependable
____ Peer conflict
____ Phobic
____ Impulsive
____ Stubborn
____ Disobedient
____ Infantile
____ Mean to others
____ Destructive
____ Trouble with the law
____ Running away
____ Self mutilating
____ Head banging
____ Rocking
____ Shy
____ Strange behavior
____ Strange thoughts
____ Fire setting
____ Stealing
____ Lying
____ Sexual Trouble
____ School Performance
____ Truancy
____ Bed wetting
____ Soiled pants
____ Eating Problems
____ Sleeping problems
____ Sickly
____ Drug use
____ Alcohol use
____ Suicide talk

Explain:

_____

_____

_____

_____

How long have these problems occurred? (number of weeks, months, years) _____

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What happened that makes you seek help at this time?

_____
_____
_____

Problems perceived to be: ____ very serious _____ serious ____ not serious

What are your expectations of your child?

_____
_____

What changes would you like to see in your child?

_____
_____

What changes would you like to see in yourself?

_____
_____

What changes would you like to see in your family?

_____

PSYCHOSOCIAL HISTORY

CURRENT FAMILY SITUATION:

Mother – Relationship to child: ____ natural parent ____ relative ____ step-parent ___ adoptive parent

Occupation _____ Education _____
Religion _____ Birthplace _____
Birth date _____ Age _____

Father – Relationship to child: ____ natural parent ____ relative ____ step-parent ___ adoptive parent

Occupation _____ Education _____
Religion _____ Birthplace _____
Birth date _____ Age _____

CHILD/ADOLESCENT CLINICAL QUESTIONNAIRE

Marital History of Parents:
Biological Parents: ____ married when _____ Age _____ _____
____ separated when _____
____ divorced when _____
____ deceased Mother or Father _____

Step-parents _____married when_____
If child was adopted – adoption source: _____

Reason and circumstances: _____

Age when child was first in the home:_____

Date of legal adoption:_____

What has child been told about his/her adoption?_____

LIVING ARRANGEMENTS: Places Dates

Number of moves in child's life _____ _____

Present Home ____ renting ___ buying _____
___ house ___ apartment _____

Does the child share a room with anyone else? _____ Yes _____ No
If yes, with whom? _____
If no, how long has he/she had own room? _____
Was the child ever placed, boarded, or lived away from the family? ____ Yes ____ No
Explain: _____
What are the major family stresses at the present time, if any? _____
_____
Any previous mental health diagnoses? _____
_____
Any Previous behavioral health services?_____
_____

Continue to the next page….

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BROTHERS AND SISTERS: (indicate if step-sibling, adopted sibling, or biological sibling)

Name	**Age**	**Sex**	**School/Occupation**	**Grade**	**Living at home**	**Substance use?**

List all other extended family members or biological family members (if child was adopted) by their relation to the patient who have drug and/or alcohol problems (legal or illegal), history of depression, self-destructive behavior, or legal problems:

Name	Problem
1.	
2.	
3.	
4.	
5.	
6.	

Others living in the home (and their relationship):

1. _____
2. _____
3. _____

HEALTH OF FAMILY MEMBERS: (excluding patient)

	Name	Relationship To child	Type of illness	When Occurred	Length of Illness
1.					
2.					
3.					
4.					

CHILD/ADOLESCENT CLINICAL QUESTIONNAIRE

Does or did any member of the child's family have any problems with:
____ reading ____ spelling ____ math ____ speech

(if yes, please explain)
_____

Is there any history in the child's family of:
____ mental retardation ____ epilepsy ____ birth defects ____ schizophrenia

(if yes, please explain)
_____

CHILD HEALTH INFORMATION:
Check all health problems the child has had or has now.

	AGE		AGE
___ High fever	_____	Dental Problems	_____
___ Pneumonia	_____	Weight Problems	_____
___ Flu	_____	Allergies	_____
___ Encephalitis	_____	Skin Problems	_____
___ Meningitis	_____	Asthma	_____
___ Convulsions	_____	Headaches	_____
___ Unconsciousness	_____	Stomach problems	_____
___ Head injury	_____	Anemia	_____
___ Concussions	_____	Accident prone	_____
___ Fainting	_____	High or Low Blood Pres.	_____
___ Dizziness	_____	Sinus Problems	_____
___ Tonsils out	_____	Heart Problems	_____
___ Vision Problems	_____	Hyperactivity	_____
___ Hearing Problems	_____	Other Illnesses, etc.	_____
___ Earaches			

Has the child ever been hospitalized? _____ Yes _____ No
If yes, please explain.

Age	How Long	Reason
_____	_____	_____
_____	_____	_____

CHILD/ADOLESCENT CLINICAL QUESTIONNAIRE

Has your child ever been seen by a medical specialist? _____ Yes _____ No
If yes, please explain.

Age	How Long	Reason
_____	_____	_____
_____	_____	_____

Has your child ever taken, or is he/she presently taking any prescribed medications?
____ Yes ____ No

Age	Medication	How Long	Reason
____	_____	_____	_____
____	_____	_____	_____

Name of Primary Care Physician
_____

DEVELOPMENTAL HISTORY:
Prenatal – Child wanted? ____ Yes ____ No Planned for? ____ Yes ____ No
Normal pregnancy? ____ Yes ____ No

If mother ill or upset during pregnancy, explain:
_____
_____
Length of pregnancy:
_____
Parental support and acceptance (explain):
_____
_____

BIRTH
Length of active labor: ___ hrs. ___ easy ___ difficult
Full Term: ___ Yes ___ No
If premature, how early:
_____
If overdue, how late:
_____

CHILD/ADOLESCENT CLINICAL QUESTIONNAIRE

Birth Weight: _____ lbs. _____ oz.
Type of delivery: ___ spontaneous ___ cesarean ___ with instruments
___ head first ___ breech
Was it necessary to give the infant oxygen ___ Yes ___ No If yes, how long? _____
Did infant require blood transfusion ___ Yes ___ No
Did infant require X-ray? ___ Yes ___ No
Physical condition of infant at birth
(If yes explain) anorexia ___ Yes ___ No
Trauma ___ Yes ___ No
Other complications ___ Yes ___ No
Did mother abuse alcohol/drugs during pregnancy? ____ Yes ___ No

NEWBORN PERIOD:

		How long
Irritability	___ Yes ___ No	_____
Vomiting	___ Yes ___ No	_____
Difficulty breathing	___ Yes ___ No	_____
Difficulty sleeping	___ Yes ___ No	_____
Convulsions/twitching	___ Yes ___ No	_____
Colic	___ Yes ___ No	_____
Normal weight gain	___ Yes ___ No	_____
Breast fed	___ Yes ___ No	_____

DEVELOPMENTAL MILESTONES:
Age at which child:

Sat up: _____
Crawled: _____

Walked: _____
Single words: _____

Sentences: _____
Bladder trained: _____

Bowel trained: _____
Weaned: _____

Describe the manner in which toilet training was accomplished?
_____
_____,

CHILD/ADOLESCENT CLINICAL QUESTIONNAIRE

SOCIAL DEVELOPMENT:

Relationship to siblings and peers:

____ individual play _____ group play
____ competitive _____ cooperative
____ leadership role _____ a follower

Special habits, fears, or idiosyncrasies of the child:

_____
_____
_____

Special interests, hobbies, skills of the child:

_____
_____
_____

EDUCATIONAL HISTORY:

		Dates attended:		Grades completed
Name of School	City/State	from	to	at this school
Preschool _____	_____	____	_____	_____
Elementary_____	_____	____	_____	_____
Junior High _____	_____	____	_____	_____
High School _____	_____	____	_____	_____

Types of classes: ___ regular ____ learning disability ____ continuation
___ opportunity ____ emotionally handicapped ____ gifted and talented
Did child skip a grade? ____ Yes ___ No Repeat a grade? ____ Yes ___ No
If yes, when and how many years? _____
Functional grade level at present time? _____
Did child have any specific learning difficulties: ____ yes ____ no
Is your child on an IEP or 504 plan _____ yes _____ no
Does child attend school on a regular basis? ____ yes ____ no
Does child appear motivated for school? ___ yes ____ no
Has child ever been suspended or expelled? ___ yes ___ no

CHILD/ADOLESCENT CLINICAL QUESTIONNAIRE

ACADEMIC PERFORMANCE:
Highest grade on last report card?

_____

Lowest grade on last report card?

_____

Favorite subject?

_____

Least favorite subject?

_____

Does child participate in extracurricular activities? ____ Yes ____ No (explain)

_____

In school, how many friends does child have: _____ a lot _____ a few ____ none

What are child's educational aspirations? ____ quit school
____ graduate from high school
____ go to college

Has child had special testing in school? ____ yes ____ no

Psychological: ___ yes ____ no Vocational: ___ yes ____ no (if yes, what were the results?)

_____

LEGAL HISTORY:
Has the child ever had difficulty with the police? ___ yes ___ no (if yes , explain)

_____

Has child ever appeared in juvenile court? ___ yes ___ no (if yes, explain)

_____

Has child ever been on probation? ___ yes ___ no

From	To	Reason	Probation Officer
_____	_____	_____	_____

EMPLOYMENT HISTORY:
Job: _____ Employer: _____ How long: _____

_____

Therapist's Signature/Credentials Date