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CHILD HISTORY QUESTIONNAIRE

To be Filled Out by Parent
Please bring this form to your initial appointment.
• If you need additional space for any of the questions, please use the back of the sheet. •

Child's Name:		Gender: ❑M ❑F	Birth Date:	Age:
Today's Date:			Email:	
Person Completing Form:			Home Phone:	
Address:			Work Phone:	
City:	State:	Zip:	Cell Phone:	
Primary Care Provider (PCP):			PCP Address:	Phone:
Clinic:				Fax:

Primary reason(s) for seeking services:

Please check behaviors and symptoms that happen more often than you would like for your child.

❑ Aggression to animals	❑ Doesn't listen when spoken to	❑ Memory problems
❑ Aggression to people	❑ Eating too much / too little / throwing up	❑ Mood changes
❑ Alcohol / Drug use	❑ Elevated mood	❑ Motivation low
❑ Anger	❑ Fatigue	❑ Nightmares / Night terrors
❑ Antisocial behavior	❑ Friendship problems	❑ Panic attacks
❑ Anxiety	❑ Gambling	❑ Phobias / Fears, of what:
❑ Arguing with adults	❑ Grades inconsistent / low	❑ Plays with younger peers
❑ Avoiding people	❑ Hallucinations	❑ Plays with older peers
❑ Baby Talk	❑ Headaches / Migraines	❑ School problems
❑ Bed wetting / soiling	❑ Heart palpitations	❑ Sexual addiction
❑ Bullies others	❑ Hopelessness	❑ Sexual identity confusion
❑ Caffeine use	❑ Homicidal thoughts	❑ Sick frequently
❑ Chest pain	❑ Hyperactivity	❑ Skipping school
❑ Compulsions / Obsessions	❑ Impulsivity	❑ Sleeping too much / too little / with parents
❑ Concentration problems	❑ Internet addiction	❑ Speech problems
❑ Conflict with peers / family	❑ Interrupts frequently	❑ Stealing
❑ Depression	❑ Irritability	❑ Stomach aches
❑ Destruction of property	❑ Judgment errors	❑ Suicidal thoughts
❑ Disorientation	❑ Loneliness	❑ Thumb sucking
❑ Disorganized thinking	❑ Loses temper	❑ Withdrawing
❑ Distractibility	❑ Low self esteem	❑ Worrying
❑ Dizziness	❑ Lying	❑ Other (specify):

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Please explain how the above symptoms are affecting your child and your family:

What are your child's greatest accomplishments?

What does your child enjoy doing the most?

What does your child dislike doing the most?

What concerns would you like to share regarding your child?

Does your child have suicidal thoughts at this time? ❑ **Yes** ❑ **No**
If Yes, explain:

Is there a history of suicidal thoughts, self-mutilation, or suicide attempts? ❑ **Yes** ❑ **No**
If Yes, explain:

PREGNANCY

How old was the mother at the time of this child's birth? _____
How old was the father at the time of this child's birth? _____

Was this pregnancy:
- ❑ Planned
- ❑ Unplanned
- ❑ Unknown if planned or unplanned

How often did this child's mother use alcohol during pregnancy?
- ❑ Unknown
- ❑ Two or more alcoholic beverages per day
- ❑ One alcoholic beverage per day
- ❑ Less than daily use but at least one drink per week
- ❑ Less than daily/weekly use but at least one drink per month
- ❑ Several drinks during the course of pregnancy
- ❑ None

How often did this child's mother smoke cigarettes during pregnancy?
- ❑ Unknown
- ❑ More than one pack per day
- ❑ One pack or less per day
- ❑ None

What medications were used by the child's mother during pregnancy?
- ❑ Unknown
- ❑ "Over-the-counter" medications – vitamins, aspirin, herbs
  Please specify: ________________________________
- ❑ Birth control pills; please specify: ________________
- ❑ Prescribed medications to prolong the pregnancy length
  Please specify: ________________________________
- ❑ Barbituates; please specify: ____________________
- ❑ Street drugs – marijuana, cocaine, speed, heroin, etc.
  Please specify: ________________________________
- ❑ Decongestants – allergy or hay fever medication, etc.
  Please specify: ________________________________
- ❑ Antibiotics; please specify: _____________________
- ❑ Other prescriptions; please specify: ______________
- ❑ None

What illnesses did this child's mother have during pregnancy? (list)

____
____
____
____
____

BIRTH

How long did labor last?
- ❑ Unknown
- ❑ No labor due to planned Caesarian (C-section)
- ❑ Less than 3 hours
- ❑ 3-12 hours
- ❑ 12-24 hours
- ❑ More than 24 hours

What type of delivery occurred?
- ❑ Induced
- ❑ Normal spontaneous
- ❑ Caesarian (C-section)

Were forceps used?
- ❑ Yes
- ❑ No

Was the child's mother awake during delivery?
- ❑ Yes
- ❑ No

Did any of the following complications of delivery occur?
- ❑ Unknown
- ❑ Premature
- ❑ Late baby
- ❑ Unusual presentation (breech, etc.)
- ❑ Umbilical cord wrapped around child's neck
- ❑ Other, please specify: ____________________________
- ❑ None

How much did this child weigh at birth? ___________
Apgar Score (if known) _______

Which of the following describes the parents' reactions to child's birth?

MOTHER	**FATHER**
❑ Happy	❑ Happy
❑ Unhappy	❑ Unhappy
❑ Mixed Feelings	❑ Mixed Feelings
❑ Unknown	❑ Unknown

Comments: ____
____

Which of the following occurred just after delivery?

❑ Unknown	❑ Breathing difficulty
❑ Incubator req'd	❑ Sucking Difficulty
❑ Jaundiced	❑ Cyanotic (blue)
❑ None	❑ Other, specify: ___________________

Early feeding history:
- ❑ Breast fed, for _____ months
- ❑ Bottle fed, for _____ months
- Colic: ❑Yes ❑No

EARLY CHILDHOOD

Please rate the following characteristics as they apply to your child's temperament during infancy (birth through 12 months).

(Check each item in one box only.)	NOT AT ALL	JUST A LITTLE	PRETTY MUCH	VERY MUCH
Unusually quiet	❑	❑	❑	❑
Cried excessively	❑	❑	❑	❑
Easily excited by sights and sounds	❑	❑	❑	❑
Easily upset by strangers	❑	❑	❑	❑
Did not like to be cuddled	❑	❑	❑	❑
Generally fussy	❑	❑	❑	❑
Irregular sleep pattern	❑	❑	❑	❑
Did not play with toys	❑	❑	❑	❑

Please rate the following characteristics as they apply to your child's temperament during pre-school childhood (2-5 years old).

(Check each item in one box only.)	NOT AT ALL	JUST A LITTLE	PRETTY MUCH	VERY MUCH
Overly active	❑	❑	❑	❑
Irregular bowel habits	❑	❑	❑	❑
Easily upset by strangers	❑	❑	❑	❑
Easily upset by changes	❑	❑	❑	❑
Withdrew from new situations	❑	❑	❑	❑
Could not persist in one activity	❑	❑	❑	❑
Generally unhappy	❑	❑	❑	❑

Please indicate the age in months at which your child was able to perform each of the following behaviors.
If possible, please consult your baby book.

Behavior	Age
First sat without support	
Walked without support	
Spoke first words	
Spoke first sentence	
Toilet training was completed	

Behavior	Age
Pointed to basic colors	
Tied own shoes	
Rode two-wheeled bicycle	
Began to read	

Other significant childhood development:

HEALTH

Does this child have any past or current health problems? If so, please list below:

Problem	When Began / Stopped	Medications Prescribed	Amount	Prescribed by (Doctor):

Is there a family history of any medical problems? If so, please describe below:

Is this child currently taking any prescription medications?

Prescription Medication	Dose	Dates	Purpose	Side effects

Is this child currently taking any over-the-counter medications, herbs, or vitamins?

Over-the-counter Medication	Dose	Dates	Purpose	Side effects

Is this child allergic to any medications?

❑Yes ❑No	If yes, describe:

	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last dental exam			
Surgeries? (specify):			
If girl, age at 1st menstruation:	Problems / Irregularities?		

What medications has this child taken for mental health problems?

	Now	Before	Dose
Ritalin, Adderall, Vyvanse	❑	❑	
Concerta	❑	❑	
Stratera	❑	❑	

	Now	Before	Dose
Other Medications	❑	❑	
Specify Name of Med:			

	Now	Before	Dose
Mood Stabilizers	❑	❑	
Antidepressants	❑	❑	
Specify Name of Med:			

❑ Child has never taken medications for mental health concerns

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FAMILY

Is this child adopted? ❑Yes ❑No (Age at adoption: ______)		
Who currently has legal / physical custody of this child? (please specify)		
❑ Biological Parents	❑ Foster Parents	❑ Adoptive Parents
❑ Biological mother only	❑ Biological father only	❑ Court
❑ Other:	Visitation arrangements if parents do not live together:	

Mother's Name:	Age:	Lives with child? ❑ Yes ❑ No
Please check one of the following to indicate mother's relationship to this child:		
❑ Biological Mother	❑ Grandmother	❑ Foster Mother
❑ Stepmother	❑ Adoptive Mother	❑ Other:

Father's Name:	Age:	Lives with child? ❑ Yes ❑ No
Please check one of the following to indicate father's relationship to this child:		
❑ Biological Father	❑ Grandfather	❑ Foster Father
❑ Stepfather	❑ Adoptive Father	❑ Other:

Parents legally married? ❑ Yes ❑ No	Parents ever separated? ❑ Yes ❑ No	Parents ever divorced? ❑ Yes ❑ No
Mother remarried? ❑ Yes ❑ No Number of times: ______	Father remarried? ❑ Yes ❑ No Number of times: ______	
Child's age when parents separated / divorced / remarried (if applicable):		
Effect on child:		

Siblings – please list relationship (brother, sister, step-relatives, half-relatives)

Name	Age	Birth Date	Relationship	Live with you?
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

Others Living in your Home

Name	Age	Relationship to child

ABUSE HISTORY

Has there been history of child abuse? ❑ Yes ❑ No	If yes, the abuse was as a: ❑ Victim ❑ Perpetrator
If yes, which types? ❑Physical ❑Verbal ❑Sexual ❑Viewed Domestic Violence	If yes, at what age did the abuse take place?
Other (please specify):	Other childhood issues: ❑Neglect ❑Inadequate nutrition
Effect on childhood development:	

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FAMILY MENTAL HEALTH HISTORY

Some of the following conditions have a genetic basis. Please indicate which of the child's blood relatives have a history with the stated problems.

	Drugs / Alcoholism	Depression	Anxiety	ADHD	Bipolar Disorder	Legal Problems	Anger Issues	Suicide Attempts
No Relative	❑	❑	❑	❑	❑	❑	❑	❑
Mother	❑	❑	❑	❑	❑	❑	❑	❑
Father	❑	❑	❑	❑	❑	❑	❑	❑
Brother(s) or Sister(s)	❑	❑	❑	❑	❑	❑	❑	❑
Maternal Grandparent	❑	❑	❑	❑	❑	❑	❑	❑
Paternal Grandparent	❑	❑	❑	❑	❑	❑	❑	❑
Maternal Aunt(s)/ Uncle(s)	❑	❑	❑	❑	❑	❑	❑	❑
Paternal Aunt(s)/ Uncle(s)	❑	❑	❑	❑	❑	❑	❑	❑
Maternal Cousin(s)	❑	❑	❑	❑	❑	❑	❑	❑
Paternal Cousin(s)	❑	❑	❑	❑	❑	❑	❑	❑

Share specific information regarding the above (medications, treatment, therapy):

SOCIAL RELATIONSHIPS

Check how your child generally gets along with other people. (Check all that apply)

❑ Loving	❑ Aggressive / Intimidates	❑ Avoids	❑ Fights / argues	❑ Follows
❑ Friendly	❑ Leads	❑ Outgoing	❑ Shy / Withdrawn	❑ Submissive
❑ Plays w/ younger kids	❑ Plays w/ older kids	❑ Plays w/ kids same age	❑ Seeks attention	❑ Defensive

❑ Other (specify):

Sexual orientation: | Comments:

ETHNICITY

To which cultural or ethnic group, if any, does your child belong?

Is he/she experiencing any problems due to cultural or ethnic issues? ❑ Yes ❑ No

If yes, describe:

Other cultural / ethnic information:

SPIRITUAL

Is your child affiliated with a spiritual or religious group? ❑ Yes ❑ No

If yes, describe:

Would you like those beliefs to be used in counseling? ❑ Yes ❑ No

If yes, describe:

LEGAL

Are you, your child, or a family member currently involved in any active legal cases (traffic, civil, criminal)? ❑ Yes ❑ No

If yes, please describe and indicate the court hearings / trial dates and charges, and its effect on your child:

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EDUCATION

How does / did your child respond to attending preschool and kindergarten?

How does your child respond to attending school now?

Currently enrolled in school? ❑ Yes ❑ No	Where?	What year?
Special circumstances (learning disabilities, gifted, etc.):		

Previous Schools Attended (please list):

School	City & State	Dates Attended	Problems / Concerns

Has Your Child Ever Been In:		When	Where	Effect
Special Education	❑Yes ❑No			
Learning Disability Program(s)	❑Yes ❑No			
Emotional Disability Program(s)	❑Yes ❑No			
Speech Therapy	❑Yes ❑No			
Special Tutoring	❑Yes ❑No			
Gifted & Talented	❑Yes ❑No			
Suspended	❑Yes ❑No			
Expelled	❑Yes ❑No			
If "Yes" to the above, please describe:				

EMPLOYMENT (if applicable)

Employer	Dates	Title	Reason for leaving	How often missed work?

LEISURE / RECREATION

What are your child's interests & hobbies?	How often now?	How often in the past?

ACTIVITIES / SPORTS

What activities and sports does your child enjoy?	How often now?	How often in the past?

How many hours per day does your child:

Read		Sleep		Talk / Text on phone	
Play with friends		Play on computer		Talk with parents / siblings	
Watch TV		Listen to music		Play alone	

EATING HABITS

Meal	How often	Typical foods eaten	Portion size			
Breakfast	/ week		❑ None	❑ Small	❑ Med.	❑ Large
Lunch	/ week		❑ None	❑ Small	❑ Med.	❑ Large
Dinner	/ week		❑ None	❑ Small	❑ Med.	❑ Large
Snacks	/ week		❑ None	❑ Small	❑ Med.	❑ Large

ALCOHOL & OTHER DRUG USE HISTORY

	Amount	Frequency	Age of First Use	Age of Last Use
Alcohol				
Marijuana				
Ecstasy				
Cocaine / Crack				
PCP / LSD / Mushrooms				
Methamphetamine / Speed				
Inhalants				
Caffeine				
Nicotine (Tobacco Products)				
Over-the-counter				
Prescription drugs				
Other (specify):				

COUNSELING / TREATMENT HISTORY

		When	Where / Provider	Reason for Treatment
Counseling	❑Yes ❑No			
Psychiatric treatment	❑Yes ❑No			
Drug / alcohol treatment	❑Yes ❑No			
Hospitalizations	❑Yes ❑No			
Involvement with self-help organizations	❑Yes ❑No			
(AA, NA, Gambling / Overeaters Anonymous)				

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What are concerns you have regarding your child?

Describe anything in your child's life (even if it had nothing to do with your child) that caused unhappiness, nervousness, anger, or put stress on their mother, father, or family:

What would you like to accomplish at the initial appointment?

What would you like to focus on in therapy sessions?

Who referred you to our clinic?
May I send them a thank-you for the referral? ❑ Yes ❑ No
(If yes, I will ask you to sign a release of information before I send a thank you.)

Please bring this form to your initial appointment.
Thank you!
-Luci