Child Initial Questionnaire

Please complete as fully as possible and bring it to your first session. This information will help me best serve you and your child.

GENERAL INFORMATION

Child's Name:_____ Today's Date:_____

Child's age:_____ Date of Birth: _____Grade: _____

Address:_____

_____

Parents Names:_____

Home phone:_____ May I leave a message? Yes No

Cell phone:_____ May I leave a message? Yes No

Work phone:_____ May I leave a message? Yes No

Email: _____ May I email you? Yes No

*Please note: I use a secure, HIPPA-compliant email server (Hushmail). All emails from me will be encrypted and require a password for you to read.

Child's primary care physician: _____Phone:_____

Address:_____

When was your child's last complete physical exam (mo/year)?_____

Child's school: _____Phone:_____

Address: _____

Did an agency/professional refer your child to my private practice?

_____

Please provide agency/professional's name, address & phone number:

_____

_____

May I contact the agency/person to thank them for referring you?
Yes No Please initial:____

(Revised 5/17)

Tell me about your child. What does he or she enjoy? What is he or she good at? What do you like most about your child? _____

_____

_____

_____

_____

_____

_____

What is the **main reason(s)** you are seeking help for your child? (Include how long he or she has had these symptoms/problems): _____

_____

_____

_____

_____

_____

_____

_____

_____

What are your **hopes** regarding your child's therapy? What are your goals?

_____

_____

_____

_____

_____

_____

_____

_____

HEALTH & MENTAL HEALTH INFORMATION

Does your child currently have any medical problems?

_____

_____

Has your child ever been treated for any of the following? If so, please check and describe.

- ☐ head injury
- ☐ loss of consciousness
- ☐ frequent ear infections, tubes placed
- ☐ hearing or vision problems
- ☐ headaches
- ☐ meningitis
- ☐ seizures
- ☐ asthma
- ☐ elevated lead levels, slow/fast growth
- ☐ allergies
- ☐ cancer
- ☐ surgeries
- ☐ any other conditions:

_____

_____

_____

_____

_____

Has your child ever experienced or suspected of experiencing the following? If so, please check and describe.

- ☐ Anxiety:_____
- ☐ Obsessive thoughts:_____
- ☐ Compulsive behaviors:_____
- ☐ Sleep problems:_____
- ☐ Trauma:_____
- ☐ Abuse:_____
- ☐ Depression:_____
- ☐ Suicidal thoughts:_____
- ☐ Inattention:_____
- ☐ Hyperactivity:_____
- ☐ Autism:_____
- ☐ Impulsivity problems:_____
- ☐ Stealing:_____
- ☐ Hurting other people or animals:_____
- ☐ Hurting himself or herself:_____
- ☐ Running away from home:_____
- ☐ Toileting accidents: _____
- ☐ Other: _____
  _____

Has your child previously seen a therapist or psychiatrist? If so, what year? Who did he/she see and for what reason? About how many meetings did your child have? Was the experience helpful or not? How so?

_____
_____
_____
_____
_____
_____

Has your child ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

_____
_____

Please list your child's current prescription medications, dosage, and prescribing physician name:

_____
_____
_____

Please list any previous psychiatric medications, dosage, and dates:_____

_____
_____

Do you suspect or know your child drinks alcohol or uses recreational drugs? If so, what kind & how often?

_____
_____

Do you or anyone close to your child consider his/her substance use to be a problem? Yes No

What types of food does he/she often eat?

Breakfast:_____

Lunch: _____

Snacks: _____

Dinner: _____

How many times a week does your child exercise?_____What type & how many minutes?_____

_____

_____

Please describe your child's sleep: (bedtime most nights, wake time most mornings, interrupted sleep, sleep waking, nightmares, toilet accidents?)

_____

_____

_____

_____

YOUR CHILD'S FAMILY

	BIOLOGICAL MOTHER	**BIOLOGICAL FATHER**
Current age, or if deceased: date, age, & cause of death		
Occupation		
Religious/Spiritual Affiliation (if any)		
Highest grade completed		
Any history of the following (please circle)	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse
Describe each parent's relationship with the child Give some examples of things that you do together & feelings you have		

Parents are (choose one): Married Separated Divorced Living Together

If separated or divorced, how old was your child when the separation occurred? _____

Child lives with (choose one): Both parents Mother Father Other

Who has legal custody? _____

Please describe the current visitation schedule (if any) and type of communication with child's other parent:

_____

Siblings

Please list your child's brothers and sisters in the order of birth (including adopted or step siblings).

First name	Biological, Adopted or Step	Age	Grade	Male/ Female	Lives with you? (Yes/No)	Any medical, social or academic problems (please list for each)?

FAMILY MENTAL HEALTH HISTORY

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate which family member.

	Please circle	List Family Member(s)
Anxiety	Yes No	
Obsessive Compulsive Behavior	Yes No	
Depression	Yes No	
Suicide Attempts	Yes No	
Bipolar/Manic Depressive	Yes No	
Alcoholism	Yes No	
Substance Abuse	Yes No	
Domestic Violence	Yes No	
Eating Disorders	Yes No	
Obesity	Yes No	
Schizophrenia	Yes No	
Counseling or Psychotherapy	Yes No	
Psychiatric Hospitalizations	Yes No	

YOUR CHILD'S DEVELOPMENTAL HISTORY

Pregnancy and Birth

Please describe any complications during pregnancy (high blood pressure, diabetes, hospitalization): _____

_____

_____

Medications used during pregnancy? Please list: _____

Smoking? Yes No How much? _____
Alcohol intake? Yes No How much? _____
Drug intake? Yes No How much? _____
Length of pregnancy?_____Weeks Age of mother at birth: _____ Baby's Birth weight: _____

Please describe any complication during birth: _____

_____

_____

Length of stay in the hospital? Mother: _____(days) Child: _____(days)

Developmental Milestones and Early Development

At what age did your child do the following (indicate approximate month or year of age for each):

Turn over _____ Crawl _____ Stand Alone_____ Walk Alone _____

First Words_____ First Phrases_____

Toilet trained? Yes No If yes, days?_____Nights? _____

Has your child wet or soiled himself after being trained? Yes No If yes, until what age?_____

Enjoyed cuddling? Yes No Fussy, Irritable? Yes No More active than other babies? Yes No

If your child has siblings, was development different in any way? Please explain:_____

_____

_____

Does your child have or used to have Early Intervention (EI) services? Please describe:_____

_____

_____

_____

YOUR CHILD'S SCHOOL, HOME, SOCIAL & PERSONAL FUNCTIONING

School/Academics

Your child's current grade? _____ Has he/she ever repeated a grade? Yes No If so, which? _____

School name: _____

Teacher's Name: _____

Address: _____

Phone: _____

What preschool/childcare experience did your child have? _____

_____

Were any problems detected in your child's kindergarten screening? Yes No If so, please explain:

_____

Is your child in a regular classroom? Yes No Does your child have an IEP ? Yes No

Has your child ever received tutoring? Yes No If so, please explain: _____

What are your child's typical grades? _____

What are your child's strongest and weakest points academically? _____

_____

Are you satisfied with your child's educational program? Yes No Please explain: _____

_____

Home/Family Life

What are some activities you engage in as a family? _____

Does your child participate in any religious or faith based group? _____

Does your child listen and obey instructions 75% of the time? Yes No

What are your discipline techniques? _____

_____

What are <u>your</u> strengths personally and as a parent? _____

What are some of <u>your</u> areas of needed growth? _____

What are your <u>child's</u> strengths (things he/she is good at)? _____

What are your <u>child's</u> areas of needed growth? _____

Social and Community Engagement

What are your child's favorite activities or hobbies? _____

In what extracurricular/community activities is he/she involved?_____

_____

How does your child get along with other children?_____

_____

Who are some of your child's closest friends (first name): _____

_____

Your Child's Symptoms or Problems

How much are <u>each</u> of the following areas currently a problem for your child?

	Not at all	**A little**	**Somewhat**	**Considerably**	**Terribly**
	1	**2**	**3**	**4**	**5**
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Parent-Child Conflicts	1	2	3	4	5
Sibling Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
School Problems	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/religious	1	2	3	4	5
Legal problems	1	2	3	4	5
Eating Disorder	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Has your child experienced any stressors (recent or during the past year) that may be contributing to his/her difficulties? (Such as illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child's changes school, family moved, family financial problems, remarriage, sexual trauma, other losses)?
Yes No

If yes, please describe:_____

_____

_____

Please provide any additional information which you would like me to know or which you feel would be helpful to better understand your child:_____

_____

_____

_____

_____

_____

_____

_____

Thank you very much for taking the time to complete this questionnaire and providing me details of your child's background. This information will help me as we explore your child's treatment goals and design his or her treatment plan.