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Child/Adolescent Questionnaire

(Please complete form for each child who will participate in therapy)

Client:
Name: _____ Today's Date:_____
Age: _____D.O.B_____
School: _____ Grade: _____

Parent/Guardian Names Marital Status Contact Phone
_____
_____

Mother:_____
Father:_____
Stepmother:_____
Stepfather:_____
Other:_____

If you are divorced/separated, is there a custody order? _____Yes_____No
(if so, and only one parent is present for the intake, you will be asked to produce a copy of the custody order prior to any subsequent appointments)

Siblings/Other Household Member's: (include age and relationship to child)
_____
_____
_____

Please describe why you are seeking treatment:
_____
_____
_____

When did the problem start?
_____
_____
_____

How would you rate the severity of the problem right now?
Mild 0 1 2 3 4 5 6 7 8 9 10 Severe

Problem Checklist
Please indicate which of the problems below are bothering the child at this time:
0= none 1= mild 2= moderate 3= serious 4= severe

0 1 2 3 4 Suicidal Thoughts/Behaviors
0 1 2 3 4 Self Harm
0 1 2 3 4 Feels Hopeless
0 1 2 3 4 Feels Worthless
0 1 2 3 4 Irritable
0 1 2 3 4 Sad/Tearful
0 1 2 3 4 Moody
0 1 2 3 4 Bully
0 1 2 3 4 Poor Sleep
0 1 2 3 4 Too Much Sleep
0 1 2 3 4 Nightmares
0 1 2 3 4 Poor Concentration
0 1 2 3 4 Excessive Worry/Fears
0 1 2 3 4 Panic
0 1 2 3 4 Irregular Eating Habits
0 1 2 3 4 Weight Preoccupation
0 1 2 3 4 Nail Biting
0 1 2 3 4 Repetitive Behaviors
0 1 2 3 4 Thumb Sucking
0 1 2 3 4 Soiling in Pants
0 1 2 3 4 Bed Wetting
0 1 2 3 4 Attention Seeking
0 1 2 3 4 Stuttering
0 1 2 3 4 Hears Voices
0 1 2 3 4 Sees Things Not There
0 1 2 3 4 Fits of Rage
0 1 2 3 4 Suspicious
0 1 2 3 4 Few Friends
0 1 2 3 4 Very Shy
0 1 2 3 4 Bossy
0 1 2 3 4 Overly Sensitive
0 1 2 3 4 Teases Others
0 1 2 3 4 Teased by Others
0 1 2 3 4 Cruel to Others/Animals
0 1 2 3 4 Lying
0 1 2 3 4 Stealing
0 1 2 3 4 Fire Setting
0 1 2 3 4 Runs Away
0 1 2 3 4 Aggression
0 1 2 3 4 Truancy
0 1 2 3 4 Sexual Acting Out
0 1 2 3 4 Legal Problems
0 1 2 3 4 Authority Conflicts
0 1 2 3 4 Tics
0 1 2 3 4 Accident Prone
0 1 2 3 4 Excessive Physical Complaints

Psychological History:
Has your child ever received mental health treatment?_____
If so, when and for how long? _____
What was the focus of treatment? _____

*Name(s) of previous therapists, address(s), phone number(s):_____
_____
Has your child ever been administered one or more psychological tests? If yes, describe:
_____
*If so, by whom (include address, phone number)? _____
_____

Has your child ever been hospitalized for mental or emotional problems? _____
If so, when and for how long? _____
Why were they hospitalized? _____
Name of the treating therapist/doctor (include address and phone number):_____
_____

Is he/she currently taking any prescription medication (if so please list):_____
_____
Who prescribes them (include address and phone number)?
_____
How long has he/she been on the medications? _____

Has he/she ever attempted suicide? _____
When?_____

Describe the circumstances that led to the attempt: _____
_____
_____
Is he/she currently having any suicidal thoughts? Please describe:
_____
Has he/she ever been the victim of a crime? Please describe:
_____
Has he/she ever been the victim of child abuse or neglect? Please describe:
_____
*List any professionals your child is currently working with:
_____

Medical History:
Has your child ever been diagnosed with a serious illness? Please describe: _____
_____
Does your child have any medical conditions that may affect his/her mental health treatment?
_____
Please describe your child's overall health today:
_____
Is your child physically active? Please describe:
_____
To your acknowledgement does your child smoke?
_____
If so, how much per week and for how long:
_____
To your acknowledgement does your child drink alcohol?
_____
To your acknowledgement has your child experimented with illegal drugs?
_____

School History:
Name of school:_____Grade:_____
Teacher:_____
Counselor:_____

Please circle Yes or No:

Learning Disabilities	Yes	No
School Avoidance/Phobias	Yes	No
Truancy	Yes	No
Behavior Problems	Yes	No
Peer Problems	Yes	No
IEP	Yes	No
504 Plan	Yes	No

Please describe your child's academic achieving and grades:_____
_____
_____

What are your child's interests/hobbies/extracurricular activities?
_____
_____

Please list anything else related to school that is important for the therapist to know:
_____
_____
_____

Family History:
Who has been the primary caregiver?_____

How well does your child get along with family members? (include all significant relationships):
_____
_____
_____
_____

Is there or has there been any violence or abuse in the home?_____
_____

Please describe any significant events in the child's life:_____
_____
_____
_____

What are your goals for your child/the family in treatment here?_____
_____
_____
_____
_____
_____
_____
_____

Thank you!

Parent/Guardian Signature Date
_____
_____