CHILD QUESTIONNAIRE
AGES 0-12

1. Name of **Primary Person** that will see the Therapist_____ **Age**_____

2. Name of **Person completing the form**_____ **Relationship**_____

Your Child's Birth History

1. Is your child **adopted**? YES NO If so, at what age? _____ Where was your child born? _____

2. Was your child **born**: FULL-TERM PREMATURE If premature how many weeks? _____

3. Was the **pregnancy planned**? YES NO

4. Please check any of the following which occurred during pregnancy:

___Prenatal care	___Good Nutrition	___Accident	___Chronic disease
___Nervous/Worried	___Headaches	___Measles	___Over/Underweight
___Unusual stresses	___Medications taken	___Toxemia	___Narcotics/alcohol intake
___Vomiting/Nausea	___Flu/high fevers	___Infections	

5. Did your **child's mother** smoke tobacco or use any alcohol, drugs or medications during the pregnancy? YES NO

6. If so, please lists which ones:

_____

7. Did the child's **mother have any problems** during the pregnancy or at delivery? YES NO If so, please describe them:

_____

_____

8. Did **mother feel depressed** after the baby's birth? YES NO

9. How well do you believe that **mother and baby bonded** after baby's birth?

_____

10. **Developmental milestones:** Please rate child on EACH of the following, using a scale of: A=average; S=slower than average; F=faster than average

_____ Smiled	_____Sat up without support	_____Stood_	____ Walked	_____Fed self
_____ Said 1st word	_____Said phrases	_____Toilet Trained	_____Dressed self	

11. Please explain any **milestone rated other than A** (average):

_____

_____

12. During the child's first year of life, was **anything present in the life of the mother or father** which caused unhappiness or anxiety, or which placed either parent under special strain (even if the event had nothing to do with the baby)? If so, please explain.

_____

_____

About Your Child's Family

1. The name of the child's **biological parents**: Mother _____

   Father: _____

2. **Marital status** of biological parents: _____ Who has **legal guardianship** of your child? _____

3. **Primary language(s)** spoken in child's home: _____

4. Child's **Ethnicity**: _____

5. Please describe any **past counseling** that either your child or family member has had:

   _____

   _____

6. Please **list family members**.

Relatives	Name	Age/Education	Does Child Get Along Well with this Person?	Grade/ Occupation
Father				
Mother				
Brother(s)				
Sister(s)				
Step-Father				
Step-Mother				
Step- Brother(s)				
Step-Sister(s)				
List all people who live in the home with this child				

7. In **the family, including yourself**, was there:

Alcoholism? Yes No Father / Mother / Siblings / Other_____

How many years drinking (roughly) ?_____

Has it been resolved?:_____

8. **Substance Abuse (including prescription)?** Yes No Father / Mother / Siblings / Self Other_____

   How many years using (roughly)?_____

Has it been resolved?:_____

Mental Illness? Yes No Father / Mother / Siblings / Other_____

How long since diagnosis?_____

9. Did they receive help? (explain) _____

10. **Serious Illness/ Disease?** Yes No Father / Mother / Siblings / Other _____

Explain:_____

_____

11. List **major changes**, including marriages, divorces, moves, major conflicts, deaths. etc, which have occurred in your family in the last 5 years. (If there are other events that happened earlier that still affect the family, please add those.)

_____
_____
_____

_____

12. **Who can you depend on** when you need help? (Please include any people, church or community programs.)

_____
_____
_____

_____

13. What **stresses** does your family struggle with? _____

_____

_____
_____

_____

14. How often does your family have **dinner together**?_____
15. How many **holidays** does your family spend together?_____
16. How often, and what **activities** do you do together as a family (church, sports, etc)?_____

About Your Child's Education

1. What **school** does your child currently attend?

   _____

Address: _____

Phone: _____ **Teachers Name**: _____

2. Current **Grade**: _____ Has your child ever **repeated a grade**? YES NO If so, which one(s)?

   _____

3. How many classes did your child A) fail last year?_____ B) failing now?_____
4. Child's **Favorite** Class/Subject_____ **Least favorite** Class/Subject_____
5. Has your child ever received **special education services**? If yes, please elaborate (under what classification):

   _____

_____

6. Has your child received any academic or psychological **testing** done at school or elsewhere? Yes No If yes, when and where?

_____

7. What do school **teachers/personnel tell you** about your child?

_____

_____

8. Has your child experienced any of the following **problems at school**? (Circle all that apply):

___fighting	___lack of friends	___drug/alcohol	____detention
___suspension	___learning disabilities	___poor attendance	____poor grades
___inattention	___incomplete homework	___behavior problems	____emotional issues

9. **Please Complete**.

Grade	Avg. Grades	Grade	Avg. Grades

Pre-K		6	
K		7	
1		8	
2		9	
3		10	
4		11	
5		12	

About Your Child's Routine

1. What kinds of **physical exercise** does your child get? _____
2. How much coffee, cola, tea, or other **caffeine** does your child consume each day?
   _____
3. Is your child's **eating restricted** in any way? How? Why?
   _____
   _____
4. **Bedtime:** _____ **Wake-up Time:** _____ **Hours of sleep** on an average night: _____
5. Does your child have any **problems getting enough sleep**? YES NO Please describe fully any problems including falling asleep, nightmares, bed wetting,
   _____
   _____
   _____
6. List assigned **chores** and how well they do them_____
7. Describe the **discipline** program you use at home._____

_____
_____

8. Do all the adults in the home **agree** on the use of this discipline program?_____
9. What does your child currently **do too often**, too much, or at the wrong times, that causes him/ her to receive discipline? Please list all the behaviors you can think of.
   _____
   _____

10. What does your child **fail to do**, as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.
    _____
    _____

11. What does your child **do that you like**? What does he/she do that other people like?
   _____
   _____

About Your Child's Health

1. Who is your child's **pediatrician**? _____
   a. When was the last visit? _____ Phone: _____
2. Any **concerns** shared by the doctor? _____

3. Has your child experienced any of the following **medical problems**? ___a serious accident ___hospitalization
   ___surgery ___asthma ___a head injury ___high fever ___convulsions/seizures
   ___eye/ear problems ___meningitis ___hearing problems ___allergies
   ___loss of consciousness
   Other:_____
4. Describe any **allergies** your child has:
   _____
   _____
5. List all **medications or drugs** your child takes or has taken in the last year—prescribed, over-the-counter, and others. Include dosages
   _____
   _____
6. What nutritional **supplements or herbs** is your child taking?_____
_____

Your Child's Social Information

1. Please describe any past or current **traumas** your child has experienced (including any abuse, physical sexual or verbal):
   _____
   _____
   _____
2. Please describe your child's **interaction with mother**:
   _____
   _____
3. Please describe your child's **interaction with father**:
   _____
   _____
4. Please describe your child's **interactions with any siblings:**
   _____
   _____
5. **How many** of your child's peers can you describe? ___None ___Some ___Most ___All
6. Do **you like** your child's peers? ___None ___Some ___Most ___All
7. How would you describe your child's **personality and/or temperament** (happy, content, fussy, quiet, irritable)?
   _____
   _____
8. Please include any **additional information** that you feel is important regarding your child:
   _____
   _____
   _____
   _____
   _____
   _____

Your Child's Treatment History & Goals

1. Has your child received **previous psychiatric treatment** or counseling? YES NO If yes, please list previous mental health professionals, dates of treatment, diagnosis (ses), and treatment effectiveness.

2. Has your child ever made statements of **wanting to hurt him/her self** or seriously **hurt someone else**? Has he/she ever purposely hurt himself or another? YES NO If yes to either question please describe the situation:

3. Has your child ever experienced any serious **emotional losses** (such as a death of or physical separation from a parent or other caretaker)? YES NO If yes, please explain:

4. Has anyone in your family been diagnosed with a **developmental or learning problem** (including autism, mental retardation, genetic disorders)? YES NO If yes, please explain:

5. Has anyone in your child's **family been diagnosed** with a psychiatric illness (anxiety, depression, suicide, schizophrenia)? YES NO If yes, please explain:

6. Describe your **main concern**:

7. What do you think **causes** this problem?

How have you **tried to solve** this problem?

8. From your preceding list of your child's behavior and your family concerns, what problem behaviors do you **want to see change FIRST**: and how much must they change for you to be **satisfied**?

9. Any **additional information** that you would like to share?

Please sign below to indicate that the information provided is true and correct:

Legal guardian : _____ Date: _____

Child Checklist of Characteristics

Please check all that apply.

	Accident prone
	Affectionate
	Aggressive
	Argues, "talks back," smart-alecky, defiant
	Assaults
	Bathroom language
	Bigoted
	Bossy to others
	Breaks rules
	Breaks the law
	Bullied by others
	Bullies/ intimidates, teases, inflicts pain on others
	Cheats
	Clowns around
	Competition
	Complains
	Complains of feeling sick
	Compliant
	Concern for others
	Conflicts at school
	Conflicts at home with parents over rule breaking, money, chores,choices
	Conflicts with friends
	Conflicts with police
	Cries easily, feelings are easily hurt
	Cruel to animals
	Dares others
	Dawdles, procrastinates, wastes time
	Daydreams
	Defiant
	Dependent, immature
	Destructive
	Developmental delays
	Difficulties with parent's paramour/new marriage
	Disobedient, uncooperative, refuses, noncompliant
	Disrupts family activities
	Distractible, inattentive, poor concentration, daydreams
	Dropping out of school
	Drug or alcohol use
	Drug sales
	Eating issues, poor manners, over/under eats, refuses
	Exercise problems
	Extracurricular activities interfere with academics
	Failure in school
	Fantasy life
	Fearful
	Feelings are easily hurt
	Fidgety
	Fighting, hitting, violent, aggressive, hostile, threatens
	Finger sucking
	Fire starting
	Fire setting
	Friendly, outgoing, social
	Hair chewing, pulling
	Head banging
	Hitting
	Hostile
	Hyperactive
	Hypochondriac, always complains of feeling sick
	Imaginary playmates, fantasy
	Immature, "clowns around," has only younger playmates
	Inappropriate sexual behaviors
	Inattentive
	Independent
	Inflicts pain on others
	Insults others
	Interrupts, talks out, yells
	Intimidated by others
	Intimidates others
	Intolerant
	Irritability
	Isolates
	Lacks organization, unprepared
	Lacks respect for authority, insults, dares, provokes
	Learning disability
	Legal difficulties, truancy, loitering, vandalism, drinking
	Lethargic
	Likes to be alone, withdraws, isolates
	Loitering
	Loss of friends
	Low-frustration tolerance, irritability
	Lying
	Manipulates
	Masturbation
	Mental retardation
	Moody
	Mute – refuses to speak
	Nail biting
	Name calling
	Needs high supervision at home over play/chores/schedule
	Negativism
	Nervous
	New school
	Nightmares
	Noisy
	Noncompliant
	Obedient
	Obesity
	Only younger playmates
	Oppositional, resists, refuses, does not comply, negativism
	Outgoing
	Out-of- seat behaviors
	Overactive, restless, hyperactive, restlessness, fidgety
	Picks on others
	Poor concentration
	Pouts
	Prejudiced, bigoted, insulting, name calling, intolerant
	Procrastinates
	Provokes others
	Rages
	Recent move, new school, loss of friends
	Refuses
	Relationships with friends are poor
	Relationships with siblings – competition, fights, teasing/provoking
	Relationships with teachers poor
	Resists
	Responsible
	Restless
	Rocking motion/behavior
	Repetitive movements
	Runs away
	Sad, unhappy
	School avoiding
	Self-harming behaviors—biting, hitting self, scratching
	Sexual preoccupation, inappropriate sexual behaviors
	Sexually active
	Shy, timid

Slow moving
Slow responding
Smart-alecky
Smoking
Social
Speech difficulties
Stealing
Stubborn
Suicide talk or attempt
Swearing, blasphemes, bathroom language, fowl language
Talks back
Teased, picked on, victimized, bullied
Teases others
Temper-tantrums, rages
Threatens
Thumb sucking, finger-sucking
Tics – involuntary rapid movements, noises or word productions
Timid
Truancy, school avoiding
Uncooperative
Uncoordinated, accident-prone
Under-active, slow-moving
Unhappy
Unprepared
Vandalism
Violent
Wastes time
Wetting/soiling of bed or clothes
Withdraws
Yells

Other: