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CHILD/ADOLESCENT BACKGROUND AND HISTORY QUESTIONNAIRE

Child's Name _____ Date of Birth _____

Home Address _____ Home Phone _____

_____

Form Completed By _____ Today's Date _____

Custody Status (check all that apply):

_____ Child lives with both biological parents
_____ Child lives with biological mother
_____ Child lives with biological father
_____ Child lives with adoptive mother and father (Age at adoption _____)
_____ Child lives with foster parent(s)
_____ Child lives with grandparent(s)
_____ Child lives with other relative(s)

Who lives in the home with your child/adolescent?

NAME	RELATIONSHIP TO CHILD	DATE OF BIRTH

Are there any siblings not living in the home?

NAME	RELATIONSHIP TO CHILD	DATE OF BIRTH

If parents are divorced or unmarried, what is the frequency of contact between your child/adolescent and the non-custodial parent?

_____

Pregnancy and Delivery

Did the child's birth mother smoke during pregnancy? YES NO

Did the child's birth mother drink alcohol during pregnancy? YES NO

Did the child's birth mother use drugs during pregnancy? YES NO

Did the child's birth mother receive prenatal care during pregnancy? YES NO

Please describe any complications with the pregnancy or delivery:

_____

_____

_____

Developmental Milestones

Please indicate the approximate age at which your child/adolescent achieved each of the following developmental milestones:

DEVELOPMENTAL TASK	AGE
First words	_____
Crawled	_____
Walked without support	_____
Toilet trained	_____

Medical History

Name and address of child's pediatrician or primary care physician:

_____

_____

_____

Are your child's immunizations up to date? YES NO

Has your child been diagnosed with any of the following medical conditions?

_____ Asthma
_____ Allergies
_____ Cancer or blood disease
_____ Cystic Fibrosis
_____ Diabetes
_____ Gastro-intestinal condition
_____ Headaches/Migraines
_____ Kidney disease
_____ Liver disease
_____ Obesity
_____ Other (Specify_____)

If yes to any of the above conditions, please describe the treatment regimen:

_____

_____

_____

Does your child have any food or drug allergies? YES NO DON'T KNOW

If yes, specify_____

Do you have any concerns with your child's dietary habits? YES NO

If yes, specify_____

Has your child/adolescent had a significant appetite change in the last month? YES NO

Comments: _____

Do you have any concerns with your child's sleeping patterns? YES NO

If yes, please specify _____

Has your child/adolescent had a significant change in sleep patterns in the last month? YES NO

Comments: _____

Behavioral/Emotional Health History

Please indicate any past or present behavioral or emotional concerns:

	PAST	PRESENT
Biting	_____	_____
Bed wetting	_____	_____
Daytime toileting accidents	_____	_____
Inattention	_____	_____
Hyperactivity	_____	_____
Fears/Phobias	_____	_____
Sad/Depressed mood	_____	_____
Eating concerns – extreme pickiness	_____	_____
Eating concerns – strict dieting	_____	_____
Eating concerns – overeating	_____	_____
Eating concerns – bingeing and purging	_____	_____
Eating concerns – excessive exercise	_____	_____
Learning problems	_____	_____
Difficulty getting along with peers	_____	_____
Social skills problems	_____	_____
Victim of teasing or bullying	_____	_____
Bullying other children	_____	_____
Arguing with adults	_____	_____
Physically harming other people or animals	_____	_____
Threatening physical harm to anyone	_____	_____
Fire starting	_____	_____
Running away from home	_____	_____

	PAST	PRESENT
Talking about or attempting suicide	____	____
Cutting or mutilating body	____	____
Obsessive thoughts and/or actions	____	____
Drug or alcohol use	____	____
Motor tics	____	____
Stuttering	____	____
Victim of physical abuse	____	____
Victim of sexual abuse	____	____
Victim of emotional abuse	____	____
Witnessed domestic violence	____	____
Other significant trauma	____	____

Please specify: _____

Other concerns

Please specify: _____

_____

_____

Has your child had previous outpatient psychological treatment? YES NO

NAME OF THERAPIST	DATES OF TREATMENT	REASON FOR TREATMENT

Has your child had previous inpatient psychological treatment? YES NO

NAME OF PROGRAM/FACILITY	DATES OF TREATMENT	REASON FOR TREATMENT

Has your child ever had a psychological or psycho-educational evaluation? YES NO

If yes, what were the results?

_____

_____

_____

Is your child/adolescent currently taking any medication (prescription, over-the-counter, vitamins, herbs, or supplements) for emotional, behavioral, academic, or medical reasons?

MEDICATION	DOSAGE	REASON

Significant Events

Please check any significant events your child/adolescent has experienced:

_____ Change of school
_____ Move to a new place
_____ Loss of someone close to the child/adolescent
_____ Serious illness or injury to a family member or friend
_____ Death in the family
_____ Frightening experience for the child/adolescent
_____ Divorce or separation
_____ Change in family structure (someone moves in/out of home, blending of families)

Education

Where does your child/adolescent currently attend school?

_____

What grade is your child/adolescent in?

Has your child/adolescent ever skipped a grade? YES NO

Has your child/adolescent ever repeated a grade? YES NO

Does your child/adolescent receive any special academic services (e.g. special education, tutoring, gifted program)? YES NO

If yes to above question, please describe:

_____

_____

Please describe any academic or school-related concerns that you have with regard to your child/adolescent:

Parents' highest grade completed: Mother _____ Father _____

Family Health History

Have any family members (siblings, parents, aunts, uncles, cousins or grandparents) been diagnosed or treated for a mental health or substance abuse problem? YES NO DON'T KNOW

Please explain if yes to above question:

Present Concerns

What are your biggest concern(s) regarding your child/adolescent?

What are your child's strengths?

Other comments:

Thank you for completing this questionnaire.