



## Confidential Child/Adolescent History Questionnaire

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Last First Middle Initial

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Race: \_\_\_\_\_ Religion: \_\_\_\_\_  
(optional) (optional)

Father: \_\_\_\_\_  
Last First Middle Initial

Mother: \_\_\_\_\_  
Last First Middle Initial

Date of Marriage: \_\_\_\_\_ Date of Divorce (if applicable): \_\_\_\_\_

Date of Death of parent (if applicable): \_\_\_\_\_ Name: \_\_\_\_\_

Step, surrogate, foster parents (explain): \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle Initial

6. Please check any of the following conditions that have applied to you over the past 6 months:

- Delay in falling asleep
- Awakening during the night
- Oversleeping/napping
- Loss of energy, feeling tired
- Moving of speaking so slowly that others notice, or the opposite
- Changes in appetite
- Weight loss or gain
- Agitation
- Sad or depressed mood
- Feelings of hopelessness
- Feelings of guilt
- Crying spells
- Hallucinations
- Obsessive thoughts/actions
- Decreased interest or pleasure in doing things
- Feeling like a failure
- Difficulty making decisions
- Wanting to be alone
- Feeling irritable
- Feeling angry
- Trouble concentrating/paying attention
- People are following me
- People are watching me
- Mood swings
- Hearing voices
- Feeling tense

- Sexual problems
- Financial problems
- Relationship problems
- Substance abuse in family
- Worrying/Anxiety
- Restless, keyed up, on edge
- Fears
- Anxiety/Panic attacks

### Physical symptoms:

- Back pain
- Headaches
- Dizziness
- Digestive problems
- Rapid heart beat/pounding heart
- Stomach pain
- Chest pain
- Shortness of breath
- Constipation or diarrhea
- Nausea or vomiting
- Other Digestive problems
- Fainting spells
- Pain in arms, legs, joints
- Pain during sexual intercourse
- History of traumatic events
- Other: \_\_\_\_\_

Child/Adolescent's Current Problems (check all that apply):

- \_\_\_\_\_ Sleeping disturbance
- \_\_\_\_\_ Eating
- \_\_\_\_\_ Bedwetting
- \_\_\_\_\_ Soiling
- \_\_\_\_\_ Seizures or convulsions
- \_\_\_\_\_ Speech difficulties

- \_\_\_\_\_ Compulsive habits (i.e. tics, nail biting, hair pulling)
- \_\_\_\_\_ Limited intelligence
- \_\_\_\_\_ Poor social relationships with other family members
- \_\_\_\_\_ Poor social relationships with other children
- \_\_\_\_\_ Poor social relationships with other adults
- \_\_\_\_\_ Resistance to authority

- \_\_\_ Learning problems
- \_\_\_ Mood swings
- \_\_\_ Suicidal thoughts
- \_\_\_ Suicidal gestures, acts
- \_\_\_ Anxieties, fears, phobias
- \_\_\_ Obsessions (repetitive thoughts)
- \_\_\_ Depression
- \_\_\_ Social withdrawal
- \_\_\_ Dependency, clinging

- \_\_\_ Assaultive acts
- \_\_\_ Sexual problems
- \_\_\_ Drug/alcohol problems
- \_\_\_ Anti-social acts, attitudes
- \_\_\_ Hyperactivity, agitation
- \_\_\_ Has difficulty expressing feelings or emotions
- \_\_\_ Inappropriate behavior, appearance, reactions
- \_\_\_ Other physical or emotional problems (explain)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

HOW LONG HAVE YOU BEEN AWARE OF THESE PROBLEMS?

- \_\_\_ One month or less
- \_\_\_ One year or less
- \_\_\_ Two years or less
- \_\_\_ Years

WITH WHOM HAVE YOU DISCUSSED THESE PROBLEMS?  
 PERSON OR PLACE/NAME/WHEN

- \_\_\_ Physician
- \_\_\_ School staff
- \_\_\_ Social agency
- \_\_\_ Clinic or other

- \_\_\_ Suspicion, persecution
- \_\_\_ Delusions (false beliefs)
- \_\_\_ Hallucinations
- \_\_\_ Anger, belligerence

Mother's pregnancy \_\_\_\_\_ Normal \_\_\_\_\_ Difficult (explain) \_\_\_\_\_  
 \_\_\_\_\_

Medications used during pregnancy: (explain) \_\_\_\_\_

Birth

- Duration of Labor \_\_\_\_\_
- Type of Delivery \_\_\_\_\_
- Difficulties, i.e. jaundice \_\_\_\_\_
- Need for extra oxygen, resuscitation \_\_\_\_\_
- How soon did mother see the baby \_\_\_\_\_
- Birth weight \_\_\_\_\_

Infancy

- Age of weaning \_\_\_\_\_
- Any feeding problems (explain) \_\_\_\_\_

- Approximate age of walking \_\_\_\_\_
- Approximate age of talking \_\_\_\_\_
- Any sleeping problems (explain) \_\_\_\_\_
- Odd behaviors, i.e. Head banging, rocking, etc. \_\_\_\_\_

Age of toilet training : day \_\_\_\_\_ night \_\_\_\_\_  
 Any problems with toilet training (explain) \_\_\_\_\_

Childhood

Does the child have fears or troublesome habits now? Or has he/she had in the past? \_\_\_\_\_

Does the child have any problems about separating from his/her parents, or did he/she ever in the past? \_\_\_\_\_

Has the child ever had any severe or long term illnesses or accidents? \_\_\_\_\_

Medical History

- 1) Name of child's doctor: \_\_\_\_\_
- 2) Approximate date of child's last physical examination: \_\_\_\_\_
- 3) Has the child been or presently on any drugs or medications? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of medication or drug	Dosage	Doctor	When started

Reason for medication or drugs:  
\_\_\_\_\_

DOES YOUR CHILD HAVE OR EVER HAD- (CHECK ALL THAT APPLY)

- \_\_\_ Diabetes
- \_\_\_ Allergies
- \_\_\_ Unusual bleeding
- \_\_\_ Cancer or tumors
- \_\_\_ Head injuries
- \_\_\_ Heart disease
- \_\_\_ Reaction to medication
- \_\_\_ Kidney disease
- \_\_\_ Liver disease
- \_\_\_ Thyroid disease
- \_\_\_ Headaches
- \_\_\_ Pregnancy
- \_\_\_ Other:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

staff only:

\_\_\_\_\_  
interviewer's signature