



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

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

- | | |
|---|---|
| <input type="checkbox"/> Sleeping disturbance | <input type="checkbox"/> Suspicion, persecution |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Delusions (false beliefs) |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Soiling | <input type="checkbox"/> Anger, belligerence |
| <input type="checkbox"/> Seizures or convulsions | <input type="checkbox"/> Assaultive acts |
| <input type="checkbox"/> Speech difficulties | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Compulsive habits (i.e. tics, nail biting, hair pulling) | <input type="checkbox"/> Drug/alcohol problems |
| <input type="checkbox"/> Limited intelligence | <input type="checkbox"/> Anti-social acts, attitudes |
| <input type="checkbox"/> Poor social relationships with other family members | <input type="checkbox"/> Hyperactivity, agitation |
| <input type="checkbox"/> Poor social relationships with other children | <input type="checkbox"/> Has difficulty expressing feelings or emotions |
| <input type="checkbox"/> Poor social relationships with other adults | <input type="checkbox"/> Inappropriate behavior, appearance, reactions |
| <input type="checkbox"/> Resistance to authority | <input type="checkbox"/> Other physical or emotional problems (explain) |
| <input type="checkbox"/> Learning problems | _____ |
| <input type="checkbox"/> Mood swings | _____ |
| <input type="checkbox"/> Suicidal thoughts | _____ |
| <input type="checkbox"/> Suicidal gestures, acts | |
| <input type="checkbox"/> Anxieties, fears, phobias | |
| <input type="checkbox"/> Obsessions (repetitive thoughts) | |
| <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Social withdrawal | |
| <input type="checkbox"/> Dependency, clinging | |

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

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. Headbanging, 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 _____

<u>Name of medication or drug</u>	<u>Dosage</u>	<u>Doctor</u>	<u>When started</u>

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