Child/Adolescent Questionnaire

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Legal Name _____

Preferred Name: _____

Date of Birth: ____/_____/_____

Sex Assigned at Birth: • M • F • Intersex _____

Gender: • M • F • Other _____

Pronouns: • He/Him/His • She/Her/Hers • They/Their/Theirs • Other

Do you have a faith-based or spiritual practice? _____

Mother's name: _____

Phone # :_____ Email:_____

Street Address: _____

Mother's name: _____

Phone #: _____ Email:_____

Street Address: _____

Father's name: _____

Phone #: _____ Email:_____

Street Address: _____

Father's name: _____

Phone #: _____ Email:_____

Street Address: _____

Client resides with: Check all that apply:

Child/Adolescent Questionnaire

• Mother • Mother • Father • Father • Stepparent • Partner

• Legal Guardian • Grandparent • Foster Parent • Other_____

Name and age of siblings residing at home:

Parent's marital status:_____

If divorced please describe your custody arrangement.

Can you supply legal documentation of this arrangement?

Presenting problem/reason for seeking treatment:

Besides therapy, how have you tried to manage this issue/concern?

Previous Psychiatric Treatment: • None • Outpatient • Inpatient

• Please describe (reason for treatment, clinician, dates of treatment, outcome_____

Has your child ever been suicidal? • Yes • No

Has your child been hospitalized for suicidal ideation or suicidal attempts?

• Yes • No If Yes, when and where?

When was the last time your child had a Physical?

Child/Adolescent Questionnaire

Date: _____

Physician's Name: _____ Physician's Phone #: _____

Psychiatrist's Name: _____Psychiatrist's Phone #: _____

Medical conditions:

Allergies:

Medications:

School environment:

• Mainstream classroom • Independent or home study • Resource class • CTE

• IEP/504 plan • Continuation school • Speech/occupational

• Special Day class therapy • Dislikes school • Tries, but does not do well

• Unmotivated • Learning problems • Missed many school days

• Gifted program • Repeated a grade • Discipline referrals

• Suspensions, how many? _____ • Expulsion, how many? _____

School name, grade & most recent teacher:

What extracurricular activities is your child involved in?

What does your child enjoy?

How much "screen time" does your child have on daily basis? (TV, phone, computer, ipad, gaming?)

Do you eat meals together as a family? If so, how often?

What activities do you do together as a family?

How much sleep does your child get per night?

Child/Adolescent Questionnaire

What do you like about your child?

Symptom Checklist

• Unresolved abuse/neglect issues • Unresolved grief/loss • Excessive sadness • Loss of enjoyment of usual activities • Irritability • Withdrawn, isolating • Feelings of emptiness • Low self-esteem • Tiredness, fatigue • Difficulty sleeping • Thoughts/attempts of suicide • Expressing a wish to die • Poor concentration • Excessive worry • Excessive fears (phobias) • Panic • Nervousness • Repeating an act over and over that is unnecessary (e.g., washing, checking, counting) • Overly concerned about germs, safety, or health • Excessive need for order, cleanliness • Overly concerned with details • Paranoia	• Weight loss/gain • Binge eating • Not eating to lose weight • Trying to lose weight by vomiting or exercising excessively • Poor body image • Hearing voices • Seeing things that aren't there • Disorientation • Nightmares • Sleepwalking • Hair-pulling • Excessive physical pain • Impulsivity • Difficulty finishing tasks • Difficulty paying attention • Excessive daydreaming • Twitching or unusual movements • Running away • Sneaking out at night • Stealing • Lying • Abusive to animals • Recurring problems with the law • Destroying property

Child/Adolescent Questionnaire

• Over-reactive • Temper outbursts • Argumentative • Defiant • Swears/uses obscene language • Blaming • Violent impulses • Harmful to others • Periods of time with very high energy level • Mood swings • Talking or thinking too fast	• Cigarette use • Alcohol use • Drug use • Bedwetting/daytime wetting • Soiling in pants • Age-inappropriate interest in sex • Questions/concerns about sexuality • Participating in high-risk sexual activity • Questions/concerns about gender or gender expression • Relationship problems • Overly sensitive to criticism • Difficulty trusting

Please describe any notable mental health or behavioral issues of family/relatives

What else do you want me to know about you or your child?

Signature:_____Date:_____

Signature:_____Date:_____