



CHILD/ADOLESCENT PATIENT HISTORY QUESTIONNAIRE

Client's name: _____ Date: _____

Gender Identity: _____ Date of birth: _____ Age: _____ Grade in school: _____

Form completed by: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (cell): _____ (work): _____

E-mail: _____

Primary reason(s) for seeking services:

- Anger/Oppositional Anxiety Coping Problems Moodiness/Irritability
- Academic Problem Fear/phobias Parenting Concerns Sexual concerns
- Sleeping problems Trauma Alcohol/drugs Hyperactivity/Impulsivity
- Compulsive Behaviors Depression Family Problems Relationship/Social Problems
- Pervasive Developmental Disorder/Autism Spectrum Gender Identity Issues
- Other mental health concerns (specify): _____

Family Background

With whom does the child live at this time? _____

Are parents divorced or separated? No Yes If yes, who has legal custody? _____
 Separated Divorced

Name(s) of step-parent(s) _____

Parent 1

Name: _____ Age: _____

Currently employed: No Yes, as _____ Education: _____

Biological Parent Step-parent Adoptive parent Legal guardian Other _____

Is there anything notable, unusual or stressful about the child's relationship with the parent?

No Yes If Yes, please explain: _____

Parent 2

Name: _____ Age: _____

Currently employed: No Yes, as _____ Education: _____

Biological Parent Step-parent Adoptive parent Legal guardian Other _____

Is there anything notable, unusual or stressful about the child's relationship with the parent?

No Yes If Yes, please explain: _____



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Client's Siblings and Others Who Live in the Household(s)

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
_____	___	_____	___ home ___ away	___ poor ___ average ___ good
_____	___	_____	___ home ___ away	___ poor ___ average ___ good
_____	___	_____	___ home ___ away	___ poor ___ average ___ good

Others living in the household(s)

Names	Age	Gender	Relationship to client (grandparent, step-parent, etc.)	Quality of the relationship with the client
_____	___	___ F ___ M	_____	___ poor ___ average ___ good
_____	___	___ F ___ M	_____	___ poor ___ average ___ good

Family Psychiatric History (circle if present in family history)

ADHD Autistic Spectrum Disorder Intellectual Disability Depression Anxiety Trauma

Obsessive Compulsive Disorder Learning Differences Personality Disorder Substance Abuse

Alcoholism Suicide Self-Harm Behavior Criminal Behavior Dementia Psychotic Disorder

Childhood/Adolescent Developmental History

Pregnancy/Birth

Any prenatal medical/emotional difficulties for the mother (e.g. surgery, hypertension, medication) No Yes

If yes, then describe _____

Length of pregnancy: _____ Birth weight and height _____ pounds _____ inches

While pregnant did the mother use tobacco? No Yes If Yes, what amount: _____

Did the mother use drugs of alcohol? No Yes If Yes, what amount: _____

Describe any birth problems or complications _____

Describe any complications for the mother or the baby after the birth _____

Infancy/Toddlerhood Check all which apply:

<input type="checkbox"/> Breast fed	<input type="checkbox"/> Milk allergies	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Bottle fed	<input type="checkbox"/> Rashes	<input type="checkbox"/> Colic	<input type="checkbox"/> Constipation
<input type="checkbox"/> Not cuddly	<input type="checkbox"/> Cried often	<input type="checkbox"/> Rarely cried	<input type="checkbox"/> Overactive
<input type="checkbox"/> Resisted solid food	<input type="checkbox"/> Trouble sleeping	<input type="checkbox"/> Lethargic	<input type="checkbox"/> Irritable when awakened

Developmental History Please denote the meeting of the following developmental milestones (A=Advanced, N=Normal, D=Delayed, SD=Significantly Delayed):

Sat alone _____ Crawled _____ Walked _____

Fed Self _____ Dressed Self _____ Spoke words _____

Spoke Sentences _____ Began Toilet Training _____ Dry All Day/Night _____ / _____

Compared with others in the family, child's development was: slow average fast



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Education

Current school: _____ Grade: _____

Does the child have an IEP/504 Plan? No Yes, describe _____

Taking Advanced Coursework? No Yes, describe _____

Favorite Subjects _____ Least Favorite Subjects _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? No Yes, describe _____

Any additional notes about the child's education that you would like to include? _____

Child's Peer Relationships

Spontaneous Follower Leader Difficulty making friends
 Makes friends easily Long-time friends Other, describe _____

How satisfied are you with your child's social interactions:

Very Satisfied Satisfied Unsatisfied Very Unsatisfied

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____

Medical/Physical Health

<input type="checkbox"/> Allergies	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Concussion
<input type="checkbox"/> Blackouts	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hives	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Influenza	<input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Lead poisoning	<input type="checkbox"/> Seizures
<input type="checkbox"/> Congenital problems	<input type="checkbox"/> Measles	<input type="checkbox"/> Severe colds
<input type="checkbox"/> Croup	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Severe head injury
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Sexually transmitted disease
<input type="checkbox"/> Stomach Aches	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Thyroid disorders
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Mumps	<input type="checkbox"/> Vision problems
<input type="checkbox"/> Ear aches	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Wearing glasses
<input type="checkbox"/> Ear infections	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Gastrointestinal Issues
<input type="checkbox"/> Eczema	<input type="checkbox"/> Skin rashes	<input type="checkbox"/> Fevers
<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Pleurisy



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List any other health concerns: _____

List any recent health or physical changes: _____

Have there been recent changes in the child's appetite? None Increased Decreased

Have there been recent changes in the child's sleep? None Increased Decreased

Has the child experienced a significant change in weight recently? No Yes, describe _____

List any hospitalizations, important accidents, and/or surgeries, head injuries, etc. _____

Pediatrician/Physician _____ Practice Name _____

Practice Address/Phone _____

All prescribed/herbal/over the counter medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Psychological/Psychiatric Treatment History

	No	Yes	When	Where/With Whom	Purpose
Counseling/Psychiatric Treatment	_____	_____	_____	_____	_____
Residential Treatment	_____	_____	_____	_____	_____
Drug/alcohol Treatment	_____	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____	_____
Psychological Testing	_____	_____	_____	_____	_____

Current Behavioral/Emotional Symptoms

Please check any of the following that are typical for your child:

- Frustrated easily
- Aggressive
- Hallucinations
- Phobias
- Bedwetting
- Short attention span
- Bullies, threatens
- Learning problems
- Lies frequently
- Stomachaches
- Suicidal threats
- Moody
- Destructive
- Panic attacks
- Eating disorder
- Sad/Depressed
- Separation anxiety
- Worries excessively
- Sexual acting out
- Hurts animals
- Impulsive
- Irritable
- Soiling
- Speech problems
- Cyber/screen addiction*
- Defiant/Oppositional
- Self-Harm Behavior
- Nightmares
- Tics or twitching
- Overweight
- Alcohol/drug use
- Angry
- Anxious/Fearful
- Hopelessness
- Sick often
- Shy, timid
- Sleeping problems
- Clumsy
- Steals
- Low self-esteem
- Suicidal attempts
- Thumb sucking
- Gender Dysphoria
- Withdrawn
- Weight loss/gain

**Please estimate the amount of time per day that your child spends in front of a screen including TV, video-games, tablet, and other hand-held devices.*

_____ Hours



Groupworks

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Other, please describe: _____

Has the child experienced death? (Friends, Family pets, Other) No Yes, please describe _____

Have there been any other significant changes or events in your child's life? (Family, Moving, Fire, etc.)

No Yes, describe _____

What are your goals for the child's therapy? _____

What family involvement would you like to see in the therapy? _____

Do you believe the child is suicidal at this time? No Yes, explain: _____

Have there been previous suicide attempts? No Yes, explain: _____

Has your child engaged in any self-harm? No Yes, explain: _____

Please use this space to provide any additional information that you believe would assist us in understanding your child?

*It is frequently helpful for me to communicate with other professionals involved with your child. Please list the names and contact information of others such as counselors, psychiatrists, pediatricians, etc. with who you would be willing for me to communicate. **Please be aware that a Release of Information Form must be signed for each.***

Staff Use

Revised 2/17

Scanned to Therapy Notes

Save As "CA History Form"

Please bring copies of any psychological testing reports to your intake appointment!