Groupworks
Psychological Services

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:

☐ Breast fed	☐ Milk allergies	☐ Vomiting	☐ Diarrhea
☐ Bottle fed	☐ Rashes	☐ Colic	☐ Constipation
☐ Not cuddly	☐ Cried often	☐ Rarely cried	☐ Overactive
☐ Resisted solid food	☐ Trouble sleeping	☐ Lethargic	☐ 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

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

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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!