

CHILD QUESTIONNAIRE
AGES 0-12

Name of Client _____

Date of Birth _____ Age _____

Address of Client _____

Legal Guardian Name/s _____

Your Child's Birth History

1. Is your child **adopted**? YES NO If so, at what age? _____ Where was your child born? _____

2. Was your child **born**: FULL-TERM PREMATURE If premature how many weeks? _____

3. Was the **pregnancy planned**? YES NO

4. Please check any of the following which occurred during pregnancy:

<input type="checkbox"/> Prenatal care	<input type="checkbox"/> Good Nutrition	<input type="checkbox"/> Accident	<input type="checkbox"/> Chronic disease
<input type="checkbox"/> Nervous/Worried	<input type="checkbox"/> Headaches	<input type="checkbox"/> Measles	<input type="checkbox"/> Over/Underweight
<input type="checkbox"/> Unusual stresses	<input type="checkbox"/> Medications taken	<input type="checkbox"/> Toxemia	<input type="checkbox"/> Narcotics/alcohol intake
<input type="checkbox"/> Vomiting/Nausea	<input type="checkbox"/> Flu/high fevers	<input type="checkbox"/> Infections	

5. Did your **child's mother** smoke tobacco or use any alcohol, drugs or medications during the pregnancy? YES NO

6. If so, please lists which ones:

7. Did the child's **mother have any problems** during the pregnancy or at delivery? YES NO If so, please describe them:

8. Did **mother feel depressed** after the baby's birth? YES NO

9. How well do you believe that **mother and baby bonded** after baby's birth? _____

10. **Developmental milestones:** Please rate child on EACH of the following, using a scale of: A=average; S=slower than average; F=faster than average

<input type="checkbox"/> Smiled	<input type="checkbox"/> Sat up without support	<input type="checkbox"/> Stood	<input type="checkbox"/> Walked	<input type="checkbox"/> Fed self
<input type="checkbox"/> Said 1 st word	<input type="checkbox"/> Said phrases	<input type="checkbox"/> Toilet Trained	<input type="checkbox"/> Dressed self	

11. Please explain any **milestone rated other than A** (average): _____

12. During the child's first year of life, was **anything present in the life of the mother or father** which caused unhappiness or anxiety, or which placed either parent under special strain (even if the event had nothing to do with the baby)? If so, please explain.

About Your Child's Family

1. The name of the child's **biological parents**: Mother _____ Father: _____

2. **Marital status** of biological parents: _____ Who has **legal guardianship** of your child? _____

3. **Primary language(s)** spoken in child's home: _____ Child's **Ethnicity**: _____

4. Please describe any **past counseling** that either your child or family member has had: _____

5. Please list family members.

Relatives	Name	Age/Education	Does Child Get Along Well with this Person?	Grade/ Occupation
Father				
Mother				
Brother(s)				
Sister(s)				
Step-Father				
Step-Mother				
Step-Brother(s)				
Step-Sister(s)				
List all people who live in the home with this child				

6. In your family, including yourself, was there:

Alcoholism? Yes No Father / Mother / Siblings / Self How Long? _____

Resolved?: _____

7. **Substance Abuse?** Yes No Father / Mother / Siblings / Self How Long? _____

Resolved?: _____

8. **Mental Illness?** Yes No Father / Mother / Siblings / Self How Long? _____

Resolved?: _____

9. **Serious Illness?** Yes No Father / Mother / Siblings / Self How Long? _____

Resolved?: _____

10. List **major changes**, including marriages, divorces, moves, deaths, etc, which have occurred in your family in the last 5 years. (If there are other events that happened earlier that still affect the family, please add those.)

11. **Who can you depend on** when you need help? (Please include any church or community programs.)

12. What **stresses** does your family struggle with? _____

13. How often does your family have **dinner together**? _____
14. How many **holidays** does your family spend together? _____
15. How often, and what **activities** do you do together as a family (church, sports, etc)? _____

16. Is there any cultural _____

About Your Child's Education

1. What **school** does your child currently attend?

Address:

Phone: _____ Teachers Name: _____

2. Current **Grade**: _____ Has your child ever **repeated a grade**? YES NO If so, which one(s)? _____

3. How many classes did your child A) fail last year? _____ B) failing now? _____

4. Child's **Favorite** Class/Subject _____ **Least favorite** Class/Subject _____

5. Has your child ever received **special education services**? If yes, please elaborate (under what classification): _____

6. Has your child received any academic or psychological **testing** done at school or elsewhere? Yes No If yes, when and where?

7. What do school **teachers/personnel tell you** about your child? _____

8. Has your child experienced any of the following **problems at school**? (Circle all that apply):

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> fighting | <input type="checkbox"/> lack of friends | <input type="checkbox"/> drug/alcohol | <input type="checkbox"/> detention |
| <input type="checkbox"/> suspension | <input type="checkbox"/> learning disabilities | <input type="checkbox"/> poor attendance | <input type="checkbox"/> poor grades |
| <input type="checkbox"/> gang influence | <input type="checkbox"/> incomplete homework | <input type="checkbox"/> behavior problems | <input type="checkbox"/> emotional problems |

9. **Please Complete.**

Grade	School	Avg. Grades	City	State
Pre-K				
K				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

11				
12				

About Your Child's Routine

1. What kinds of **physical exercise** does your child get? _____
2. How much coffee, cola, tea, or other **caffeine** does your child consume each day? _____
3. Is your child's **eating restricted** in any way? How? Why? _____

4. **Bedtime:** _____ **Wake-up Time:** _____ **Hours of sleep** on an average night: _____
5. Does your child have any **problems getting enough sleep**? YES NO Please describe fully. _____

6. **Curfew:** A) school nights _____ B) weekend/holiday nights _____
7. List assigned **chores** and how well they do them _____

8. Describe the **discipline** program you use at home. _____

9. Do the adults in the home **agree** on the use of this discipline program? _____
10. What does your child currently **do too often**, too much, or at the wrong times, that gets him/her in trouble? Please list all the behaviors you can think of. _____

11. What does your child **fail to do**, as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of. _____

12. What does your child **do that you like**? What does he/she do that other people like? _____

About Your Child's Health

1. Who is your child's **pediatrician**? _____ When was the last visit? _____
 Address: _____ Phone: _____
2. Any **concerns** shared by the doctor? _____

3. Has your child experienced any of the following **medical problems**?

___ surgery	___ asthma	___ a head injury	___ high fever	___ hospitalization
___ eye/ear problems	___ meningitis	___ hearing problems	___ allergies	
___ loss of consciousness	___ other _____			
4. Describe any **allergies** your child has: _____
5. List all **medications or drugs** your child takes or has taken in the last year—prescribed, over-the-counter, and others. Include dosages please _____

6. What nutritional **supplements or herbs** is your child taking? _____

These Questions are regarding older children.

7. Is this child in a **gang**? _____ Has this child used **drugs**? _____. If so, describe which drugs, frequency, age at first use, and amounts. _____

8. Has this child ever been **pregnant or fathered a child**? YES NO If yes, please tell what happened with each pregnancy: _____

Your Child's Social Information

1. Please describe any past or current **traumas** your child has experienced (including abuse, physical sexual or verbal): _____

2. Please describe your child's **interaction with adults**: _____

3. Please describe your child's **interaction with other children**: _____

4. **How many** of your child's peers can you describe? ___None ___Some ___Most ___All

5. **Do you like** your child's peers? ___None ___Some ___Most ___All

6. Have any of your child's friends been **in trouble** with the law? ___None ___Some ___Most ___All

7. How would you describe your child's **personality and/or temperament** (happy, content, fussy, quiet, irritable)? _____

8. Please include any **additional information** that you feel is important regarding your child: _____

Your Child's Treatment History & Goals

1. Has your child received **previous psychiatric treatment** or counseling? YES NO If yes, please list previous mental health professionals, dates of treatment, diagnosis (ses), and treatment effectiveness. _____

2. Has your child ever made statements of **wanting to hurt him/her self** or seriously **hurt someone else**? Has he/she ever purposely hurt himself or another? YES NO If yes to either question please describe the situation: _____

3. Has your child ever experienced any serious **emotional losses** (such as a death of or physical separation from a parent or other caretaker)? YES NO If yes, please explain: _____

4. Has anyone in your family been diagnosed with a **developmental or learning problem** (including autism, mental retardation, genetic disorders)? YES NO If yes, please explain: _____

5. Has anyone in your child's **family been diagnosed** with a psychiatric illness (anxiety, depression, suicide, schizophrenia)? YES NO
If yes, please explain: _____

6. What is your **main concern**? _____

7. What do you think **causes** this problem? _____

8. How have you **tried to solve** this problem? _____

9. From your preceding list of your child's behavior and your family concerns, what problem behaviors do you **want to see change FIRST**:
and how much must they change for you to be **satisfied**? _____

10. Any **additional information** that you would like to share? _____

Please sign below to indicate that the information provided is true and correct:

Legal guardian : _____ Date: _____