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Child Questionnaire

As your psychologist, this form will provide me with important information that will be useful in understanding and working with your child and family.

Today's date:_____

This form filled out by: (please print your full name)

_____

Relationship to the child:_____

Please complete all items that are pertinent:

Identifying Data

Child's full name:_____

Date of birth:_____ Age:_____

School or preschool:_____

Grade:_____Teacher's name:_____

Members of the child's current household:

Name:_____ Age:_____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list additional household members on the back of this page.

Other adults involved with the child's care:

Name and relationship with the child:

_____ Age:_____

_____ _____

_____ _____

_____ _____

If child is part of a blended family, or if parents are divorced how has custody been arranged?

_____

_____

_____

_____

Reason for Referral

Who referred you?

_____

What is the problem or symptoms that concern you?

_____

_____

_____

_____

When did you first become concerned about this problem?_____

_____

_____

What changes would you like to see for your child and family? _____

_____

_____

_____

Please check any of the following which currently apply to your child:

Headaches	_____	Feels bad about self	_____
Dizziness	_____	Worried about sexual matters	_____
Fainting spells	_____	Living in a dreamlike or make-believe world.	_____
Fast heartbeat	_____	Seems out of touch with reality	_____
Rashes	_____	Hears voices others do not hear	_____
Stomach trouble	_____	Has few or no friends	_____
No appetite	_____	Withdrawn	_____
Overweight	_____	Shy	_____
Weigh loss	_____	Difficulty controlling anger	_____
Bowel disturbance	_____	Aggressive behavior	_____
Soiling self	_____	Cruel to others	_____
Poor bladder control	_____	Cruelty toward animals	_____
Sleep problems	_____	Selfish	_____
Fatigue	_____	Destructive	_____
Nightmares	_____	Sets fires	_____
Night terrors	_____	Won't obey parents	_____
Feels tense	_____	Lying	_____
Fearful	_____	Tantrums	_____
Worries a lot	_____	Stealing	_____
Feels panicky	_____	Wandering	_____
Tremors	_____	Runs away from home	_____
Needs others too much	_____	Easily frustrated	_____
Difficulty making decisions	_____	Can't sit still	_____
Feels sad or unhappy	_____	Always on the go	_____
Feels inferior to peers	_____	Restless	_____
Frequently feels guilty	_____	Short attention span	_____
Thinks about hurting self	_____	Clumsy	_____
Suicidal behavior or threats	_____	Acts younger than age	_____
Difficulty making friends	_____	Poor school work	_____
Difficulty keeping friends	_____	Poor social behavior in school	_____
Feels lonely	_____	Fears school	_____
Fears others	_____		

Treatment History

Please indicate your child's previous history of treatment for behavioral, emotional or problems related to his/her psychological well-being. In addition, if your child or family is currently working with another professional, agency or organization, please list them below.

1._____

2._____

3._____

4._____

Please, briefly describe your child or family's previous treatment as well as the issue that was addressed in counseling or therapy. Was it helpful?

_____

_____

_____

_____

Family Information

Information about the child's biological father:

Name_____ Date of birth_____

Living? _____ Where_____

Employer_____ Occupation_____

If not living with child, when did separation occur and what is his current relationship with your child?

_____

_____
_____

_____

Information about child's biological mother:

Name:_____ Date of birth_____

Living?_____ Where_____

Employer_____ Occupation _____

If not living with child, when did separation occur and what is her current relationship with your child?

_____

_____

_____

_____

If applicable, information about child's stepfather:

Name_____ Date of birth_____

Living?_____ Where?_____

Employer_____ Occupation_____

How long has stepfather been in a parental role with your child? _____

_____

_____

If applicable, information about child's stepmother:

Name_____ Date of birth_____

Living? _____ Where? _____
Employer _____ Occupation _____

How long has stepmother been in a parental role with your child? _____

_____

_____

Please list siblings not living with your child, i.e., brothers, sisters, stepbrothers, stepsisters, adopted brothers and sisters.

Name	Age	Gender	Relation to child brother, sister, etc.
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Family Medical and Psychiatric History

Please describe your child's family neurological and psychological history, and if known, your relative's diagnosis.

_____

_____

_____

_____

_____

_____

Does your child's family have a history of suicide? If so, please describe.

_____

_____

_____

_____

Is there a history in your child's family of learning disabilities, attention deficit/hyperactivity disorders or autistic spectrum disorders? Please describe:

_____

_____

_____

_____

_____

_____

Please check if your child has had any of the following:

___ Roseola

___ Serious accidents/injuries

___ Head injuries

___ Asphyxiation

___ Seizure disorder

___ Whooping cough

___ Measles

___ Eczema

___ High fever

___ Pneumonia

___ Asthma

___ Difficult birth

___ Chronic ear infections

___ German measles

___ Scarlet fever

___ Allergies

___ Poisoning (including medications) ___ Infections

___ Swallowing non-food items ___ Constipation

___ Allergic reaction to immunizations, i.e., DPT, polio, etc.

___ Hospitalizations (psychiatric or medical)

___ Coordination problems, i.e., difficulty learning to tie shoes, riding a bike, jumping rope, etc.

___ Problems identified with sensory integration, sensitivity to sound, light or touch.

___ Difficulty gaining weight or height

___ Confusion with directions (left/right)

Please describe any additional medical problems your child has had or is currently experiencing:

_____

_____

_____

_____

_____

_____

Date of his/her last physical examination: _____

Child's physician: _____

Physician's phone number: _____

Child's currently prescribed medications and dosage: _____

_____

_____

Your Child's Developmental History

Where was your child born? Please describe where he/she has lived until now.

_____

_____

_____

_____

Please describe at what age did the follow developmental milestones occur? If they have not yet occurred please write "n/a":

_____Sat alone

_____Crawled

_____Walked

_____First words

_____First sentences

_____Bladder control

_____Bowel control

_____Weaned

_____Recognized mother

_____Showed fear of strangers

Please check below if your child displayed any of these behaviors during his/her first months of life. Check as many as apply:

_____Cried a lot

_____Difficult to console

_____Pushed away when cuddled

_____Irritable

_____Easily Startled

_____Responsive to sound of mother's voice

_____Overly sensitive

_____Smiley

_____Cuddly

_____Overly active

_____Passive

_____Responsive to sound of father's voice

If the child's mother was not their primary caregiver during infancy or early childhood, who was? Please describe the role that caregiver currently has in the child's life.

_____

_____

_____

If your child has lived outside the home and/or been physically or emotionally separated from their primary caregiver at any point in their life, please describe the nature of the separation and current impact it may have on your child.

_____

_____

_____

_____

_____

Please indicate any significant events that have occurred within the family that may have been particularly upsetting or have had a negative impact on your child's psychological development. Please include such events as separation or divorce of child's parents, birth of siblings or stepsiblings, adoption of another child, deaths of family members or close relatives, moving to a new house or community, prolonged absences of one parent, illness of a parent, financial problems, criminal or legal problems involving family members.

_____

_____

_____

_____

_____

_____

Please check if your child has presented with any of the following behaviors during periods of stress or if they occur for no apparent reason.

_____Unusual fears

_____Banging head

_____Aggressive kicking

_____Biting

_____Argumentative

_____Temper Tantrums

_____Difficulty separating from parents

_____Poor social skills

_____Holds breath

_____Overly sensitive to sound

_____Overly sensitive to light

_____Frequently breaks rules at home

_____Frequently breaks rules at school

_____Frequent conflict with one or both parents/guardians

_____Frequent conflict with siblings

_____Problems sleeping

_____Overly compliant

Schools your child has attended:

Name of School	Resource or Special Ed	TAG

Preschool: _____

Kindergarten: _____

Elementary school:

1st Grade: _____

2nd Grade: _____

3rd Grade: _____

4th Grade: _____

5th Grade: _____

Name of School Resource or Special Ed. TAG

Middle School

6th Grade: _____

7th Grade: _____

8th Grade: _____

High School

9th Grade: _____

10th Grade: _____

11th Grade: _____

12th Grade: _____

Please indicate if as your child progressed in school, if he or she developed any academic or social problems. If so, please describe the onset and nature of these problems:

_____

_____

_____

_____

Currently or in the past has your child received speech, physical or occupational therapy? If so, please describe the nature of the problem, if treatment was effective and if treatment is ongoing.

_____

_____

_____

_____

What are your child's special interests or hobbies?

_____

_____

_____

_____

What do you consider to be your child's strengths?

_____

_____

_____

_____

What do you like most about your child?

_____

_____

_____

_____

Please indicate any additional information that you think is important for me to know about your child.

_____

_____

_____

_____

_____