# Child/Adolescent History Questionnaire

Child's Name: ________________________________________ Date: ________________________________

Completed by: ____________________________________ Relationship to Child: ______________________

Child's Gender at Birth: ____________________________ DOB: ________________________ Age: _______

Child's Ethnicity/Race:

________ African American ________ Bi-racial _________ Hispanic/Latino _________ Pacific Islander

________ Asian American ________ White/Caucasian _________ Native American __________ Other

If other, please describe: ____________________________________________________________________

With whom does the child primarily reside? Please circle one:

**Natural Parents** **One Parent Alone** **Parent & Step Parent** **Foster/Adoptive Parents**

**Legal Guardian** **Other (specify): _________________________________________________________**

Is your child currently on probation? YES NO

School child attends: _______________________________________________________________________

School District: __________________________________________ Grade Level (now): __________________

Has your child ever been retained? YES NO If yes, what grade? __________________________________

Please check if your child has any of the following:

**_________Special Education Accommodations or a 504 _________ An Individual Education Plan (IEP)**

**_________Diagnosed Learning Disability __________Receiving special services at school**

Is your child presently receiving counseling elsewhere? YES NO

**(If yes, do not complete this form until you have talked with your counselor)**

History of learning, emotional, behavioral problems: YES NO
If yes, please explain:

______________________________________________________________________________

______________________________________________________________________________

Has your child ever seen a mental health professional (psychiatrist, psychologist, or counselor)? YES NO
**(If so, we may need your permission in order to communicate with that individual or agency)**

Previous Mental Health Professional/Agency: (please add dates of service beginning-ending)

______________________________________________________________________________

Are you seeking services because your child is a victim of a crime? YES NO

Did it result in legal action? YES NO **If yes, explain:** ___________________________________________

Has the client or anyone in the client's family experienced abuse or neglect? YES NO

Is the client currently experiencing abuse or neglect? YES NO

Is there a history of CPS involvement? YES NO **If yes, please explain:**

______________________________________________________________________________

**Mother/Legal Guardian Information**

Name: ___________________________________ Age: ____________ Occupation: _________________________

Where employed: __________________________ Highest education completed: _________________________

I am: **_____ biological mother _____ stepmother _____ adoptive mother Other: ____________________**

History of medical or learning difficulties: __________________________________________________________

Current living arrangements:

**_____ Family of Origin ______ Single _____ Spouse/Partner ______ Roommate _____ Cohabiting**

**Other:________________**

Martial Status: (indicate all that apply and duration of each, ex. 1965-1985)

_____Never married ___________Currently married ___________Divorced ___________Widowed

**Father/Legal Guardian Information**

Name: __________________________________ Age: ____________ Occupation: _________________________

Where employed: __________________________ Highest education completed: _________________________

I am: _____ **biological father** _____ **stepfather** _____ **adoptive father** **Other: _____________________**

History of medical or learning difficulties: __________________________________________________________

Current living arrangements:

**_____ Family of Origin ______ Single _____ Spouse/Partner ______ Roommate _____ Cohabiting**

**Other:________________**

Martial Status: (indicate all that apply and duration of each, ex. 1965-1985)

_____Never married ___________Currently married ___________Divorced ___________Widowed

***Primary Household*** (anyone who currently lives with child)

How long in this current living situation: ______________

| Name | Age | Gender | Relationship to Child | Quality of relationship with the child |
|---|---|---|---|---|
| | | | | _____poor _____ average _____good |
| | | | | _____poor _____ average _____good |
| | | | | _____poor _____ average _____good |
| | | | | _____poor _____ average _____good |
| | | | | _____poor _____ average _____good |
| | | | | _____poor _____ average _____good |

***Secondary Household*** (non-custodial or extended family – if applicable)

| Name | Age | Gender | Relationship to Child | Quality of relationship with the child |
|---|---|---|---|---|
| | | | | _____poor _____ average _____good |
| | | | | _____poor _____ average _____good |
| | | | | _____poor _____ average _____good |
| | | | | _____poor _____ average _____good |
| | | | | _____poor _____ average _____good |
| | | | | _____poor _____ average _____good |

Currently involved in a custody dispute: NO YES **(If yes, explain)** ________________________________

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If divorced, circle the number which best describes your relationship with your ex-spouse.

Hostile Neutral Friendly
1 ---------------------2---------------------3---------------------4---------------------5

How often does the child see non-custodial parent? ________________________________________________

**Religion/Spirituality**
Does religious faith play an important part in the life of the child's family? YES NO

If so, what faith based community do you belong/attend: ____________________________________________

What religious/spiritual activities does your family participate in? For example, daily prayer, reading of scripture, etc.

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Gender: ______**Male** ______**Female** ______**Non-Binary (3rd gender)** _______________**Prefer to self describe**

_______**Prefer not to say**

Sexual Orientation: ______**Straight/Heterosexual** _____**Gay, lesbian, or queer** ______**Bisexual**

_______________**Prefer to self describe** _______**Prefer not to say**

**Pregnancy and Birth History**

Was your child adopted? YES NO **If yes, at what age? ________________**

**If yes, was it a(n): _____Domestic Adoption _____International Adoption (Country: ____________________)**

Were there any complications during pregnancy? YES NO **If yes, please explain:**

________________________________________________________________________________

Was your child born prematurely? YES NO **If yes, please explain:**

________________________________________________________________________________

Were there any complications during birth? YES NO **If yes, please explain:**

________________________________________________________________________________

Child's weight at birth: ____________lbs. _____________oz. Post-partum depression? YES NO

Child's health at birth: ___________________________ Length of hospital stay: ________________________

**Infancy/Toddlerhood** (check all which apply)

____ Breast Fed ____Milk Allergies ____Vomiting ____Diarrhea _____Bottle Fed _____Rashes
____Colic ____Constipation ____Not Cuddly ____Rarely Cried _____Overactive _____Lethargic
____Resisted solid food _____Trouble sleeping _____Irritable when awakened

Did your child meet typical developmental milestones? YES NO

**If no, which milestones were not met at the typical time? And has your child now met those milestones?**

________________________________________________________________________________

________________________________________________________________________________

Did you have concerns about your child's development in any of the following areas below?

_____Speech/Language _____Motor Skills _____Cognitive/Intellectual _____Sensory _____Behavioral

_____Emotional ______Social

Compared with others in the family, child's development was: _____Slow _____Average _____Fast

Were there any significant disturbances/changes during your child's childhood? YES NO
**If yes, please explain:**

________________________________________________________________________________

**Child's Health History**

Does your child have any health issues? YES NO
**If yes, please explain:**

____________________________________________________________________________________

Is your child taking any medications? YES NO
**If yes, please list:**

____________________________________________________________________________________

Has your child ever had a serious accident/illness or hospitalization? YES NO
**If yes, please explain:**

____________________________________________________________________________________

Has your child had/required any surgeries? YES NO
**If yes, please explain:**

____________________________________________________________________________________

**Foster Care Involvement**
Has your child ever been in foster care? YES NO UNKNOWN

**If yes, from what ages? ________________________ Reason: _______________________________**

Type of placement: _______Familial Placement _______Non-Familial Placement

**Safety Concerns**
Is your child presently suicidal? YES NO **If yes, please explain:**

____________________________________________________________________________________

Has your child ever attempted suicide? YES NO **If yes, when and how:**

____________________________________________________________________________________

Is there a history of suicide in your child's immediate and/or extended family? YES NO

Is your child presently homicidal? YES NO **If yes, please explain:**

____________________________________________________________________________________

**Current Functioning**

Do you have concerns about your child in the following areas?

_____ Eating ______Hygiene/Grooming _____Sleeping _____Activities/Play _____Social relationships

**If so, please explain:**

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Approximately how many cups of water does your child drink each day? ________________________________

How often does your child eat during a typical day? ___________________________________________________

Symptoms causing concern, distress, or impairment:

Change in sleep patterns: **sleeping more** **sleeping less** **difficulty falling asleep**

**difficulty staying asleep** **difficulty waking up** **difficulty staying awake**

Concentration: **Decreased Concentration** **Increased Concentration**

Change in appetite: **Increased appetite** **Decreased appetite**

Increased anxiety (describe): _______________________________________________________

Mood swings (describe): ___________________________________________________________

Behavioral problems/changes (describe):

______________________________________________________________________________________

______________________________________________________________________________________

Any recent significant events: **Death of a family member/friend** **Change to Health** **Change in Lifestyle**

**Loss/Change of Job** **Change in Income** **Change in Housing** **Deployment of a Family member** **None**

What do you enjoy most about this child? _______________________________________________________

What are the family's favorite activities?_____________________________________________________

What does the child/adolescent do with unstructured time?_________________________________________

Has the child/adolescent experienced death? (friends, family, pets, other) YES NO **What age?__________**

Any additional information that you believe would assist us in understanding your child/adolescent?

______________________________________________________________________________________

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

Does your child have a job? YES NO **If yes, what is their occupation and where do they work?**

_____________________________________________________________________________________________

Is your child free to quit their job if they choose to? YES NO **If no, please explain:**

_____________________________________________________________________________________________

Check all that the client is experiencing: **Circle the most significant issue.**

___Thoughts of suicide
___Thoughts of death
___Plans to harm self
___Thoughts of harming others
___Plans to harming others
___Self-injury
___Loss of meaning in life
___Loss of hope
___Depression
___Decreased pleasure
___Lack of activities
___Isolating/withdrawn
___Decreased energy/fatigue
___Significant weight change
___Feelings of worthlessness
___Grief
___Loneliness
___Guilt feelings
___Feelings of shame
___Anxiety
___Excessive worry
___Panic Attacks
___Chronic fear
___Irrational fears
___Stress
___Obsessions
___Compulsions
___Phobias
___Feel like I'm losing control
___Restlessness
___Muscle tension

___Problems with memory
___Avoid open spaces
___Behavioral problems
___ADHD
___Rage
___Anger/aggression
___Irritability
___Relationship to parents
___Relationship to children/peers
___Sexual problems
___Sexual orientation
___Gender identity issues
___Conflicts at work
___Problems in school
___Loss of faith in God
___Religious doubts
___Substance use problems
___Hallucinations
___Delusions
___Easily distracted
___Relationship to significant other
___Current or past physical abuse
___Current or past sexual abuse
___Current or past emotional abuse
___Current or past neglect
___History of abandonment

___Suspected sexual abuse
___History of family domestic violence
___Learning difficulties
___Problems with teachers
___Disturbing memories
___Nightmares/night terrors
___Running away
___Stealing
___Inappropriate sexual behavior
___Bedwetting or soiling
___Overly Affectionate/attachment
___Alcohol problems
___Bullies, threatens
___Careless/reckless
___Chest pains
___Self-esteem/self-confidence
___Head banging
___Lies frequently
___Teeth grinding
___Thumb sucking
___Severe Headaches
___Dizziness
___Human Trafficking
___Robbery
___Oppression
___Discrimination

What else is client experiencing at this time? ______________________________________________________

When did you first become concerned about the main/most significant issue?____________________________

How have you attempted to cope/deal with this issue before now?

__________________________________________________________________________________________

__________________________________________________________________________________________

**Family Mental Health History**

Please identify if any members of your child's family have had a history of any of the following mental health/drug abuse/legal concerns (check all that apply and identify who for each):

Depression:_______________________________________________________________________________

Anxiety: _________________________________________________________________________________

Bipolar Disorder: __________________________________________________________________________

Schizophrenia:_____________________________________________________________________________

ADHD/ADD:________________________________________________________________________________

Trauma History:____________________________________________________________________________

Alcohol Abuse:____________________________________________________________________________

Drug Abuse:_______________________________________________________________________________

Incarceration:______________________________________________________________________________

Who does/can your child counts on for support:___________________________________________________

**Additional Information:** Please use the following section to list any additional information that you deem important/relevant:

__________________________________________________________________________________________

__________________________________________________________________________________________

**Individual(s) completing form:**

Printed Name (primary person): ________________________________ Date: ____________________

Signature: ____________________________________________

Printed Name (secondary person): ________________________________ Date: __________________

Signature: ____________________________________________