Integrity Psychological and Counseling

Child / Adolescent Questionnaire

Name:_____ Age:_____ ☐ Male ☐ Female Date of Birth:_____

Telephone number: _____ Who referred child? _____

Social History

Housing

Is child living with ☐ Parents ☐ Friends ☐ Relatives ☐ Foster Home ~ Other _____

Length of time at current residence: _____

People living in the same home with the child:

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family members living outside of the home:

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Education

School name: _____ Grade: _____

Does child have learning problems in school? ☐ No ☐ Yes If yes, specify _____

Have grades changed recently? ☐ No ☐ Yes

Does child attend any special education classes? ☐ No ☐ Yes If yes, specify_____

Does child have behavior problems in school? ☐ No ☐ Yes

Has child ever been expelled or suspended? ☐ No ☐ Yes

If yes were drugs or alcohol involved? ☐ No ☐ Yes ☐ Unsure

If yes, specify_____

Stressors

Has your child experienced any significant events within the past year (death of a loved one, parental job problems, moves, separation of parents/caretakers)? ☐ No ☐ Yes

If yes, specify: _____

Medical

Treating physician: _____

Current medications: _____

Trauma

Was child:

Victim of domestic violence	☐ No ☐ Yes	Raped	☐ No ☐ Yes
Emotional or verbally abused	☐ No ☐ Yes	Neglected	☐ No ☐ Yes
Physically abused	☐ No ☐ Yes	Witness of violence	☐ No ☐ Yes
Sexually abused	☐ No ☐ Yes	Separated from family	☐ No ☐ Yes

Other:_____

Has child participated in any abusive behavior toward others? ☐ No ☐ Yes

Prenatal and Delivery
During the course of pregnancy did mother:
□ Take medications □ Use drugs □ Smoke □ Drink alcohol □ NA
Were there prenatal complications? □ No □ Yes If yes, specify: _____
Was child full term? □ No □ Yes
If no, specify: _____
Were there delivery complications? □ No □ Yes
If yes, specify: _____

Childhood
Has your child:
Had a fever above 105? □ No □ Yes
Had accidents/injuries? □ No □ Yes
Lost consciousness? □ No □ Yes
Had a drug allergy? □ No □ Yes If yes, specify: _____
Been hospitalized? □ No □ Yes If yes, specify: _____
Childs' achievement of developmental milestones (crawling, walking, talking, etc.) were:
□ Below Average □ Average □ Above Average
History of bedwetting? □ No □ Yes
History of soiling pants? □ No □ Yes
Major health problems? □ No □ Yes If yes, specify: _____

Adolescence - 12 to 18 years old or as appropriate
Did physical maturity occur around the same age as most peers? □ No □ Yes
If female, have menstrual periods started? □ No □ Yes If yes, age of onset: _____
Age of first sexual experience: _____
Has your child run away? □ No □ Yes
Major health problems? □ No □ Yes If yes, specify: _____

Sleep
What time does your child go to sleep at night? _____ Wake up in the morning? _____
Restful □ No □ Yes Is sleep a problem for patient? □ No □ Yes
If yes, specify: _____
_____

Nutrition
Number of meals per day_____
Concerns about nutrition □ No □ Yes If yes, specify: _____

Drug Usage
Does your child use any of the following? □ Alcohol □ Tobacco □ Caffeine □ Drugs (other than prescribed)
If yes, for how long and in what amounts? _____
_____
_____

Legal History
Has your child been charged with a crime other than a minor traffic violation? □ No □ Yes
Specify (note any felony charges)_____
_____
Was this admission prompted by the criminal justice system (e.g. Judge, Probation Officer)? □ No □ Yes

Signature of Person Completing Form: _____ Date: _____

Relationship to child: _____

Clinician Signature: _____ Date: _____