Initial Child/Adolescent Questionnaire

Date: _____
Patient Name: _____ Date of Birth: _____/_____/_____
Age of Patient: _____ Name of person completing this form_____
Relationship to Patient: _____

Dear Parent: The information that you provide is critical in providing an accurate diagnosis and treatment of the problem. If you require additional space to answer any of these questions, please write on the back of the page and list the number of the question being answered. If you do not know the answer to a question please leave it blank.

I. Please describe, in detail, the present problem (including when the problem started, how often it occurs, what stressors may contribute to the problem, etc.)

Has your child received any previous treatment for the problem? Yes No If yes, explain:

II. **Medical History**:

Name of Pediatrician or Family Doctor: _____

Date last seen: _____

Would you like our findings and recommendations sent to your pediatrician? Yes No

Please check any of the following medical conditions for which your child was ever evaluated or diagnosed:

Seizures	Heart Problems	Weight Problems	Head Injury
Asthmatic condition	Chronic Fatigue	Chronic Headaches	Depression
Chronic Hearing Loss	Stomach Problems	Suicidal Thoughts	Surgeries

Other _____

Please explain any item that you checked and list any medication(s) that were *previously* prescribed.

Allergies (Please list all of your child's allergies):

Current Medications (Please list all of your child's current medications other than above):

III. Past Psychiatric/Psychological History:

Has your child ever received psychiatric services or counseling? Yes No If yes, please explain and include dates of service, location, physician or counselor's name.

List any psychiatric or mood medications that your child has been prescribed in the past (if more than 3 medications, use the back of this page):

Name of medication	Prescribed by	Dose level	Side effects
1.			
2.			
3.			

IV: Developmental History:

A: Relating to your child's birth:

Your child's weight at birth: ____lbs. ____oz. Was this a full term birth? Yes No If no, explain:

Did either parent use drugs or alcohol at the time of conception? Yes No If yes, explain:

Were there any complications with the labor & delivery such as jaundice, infection etc.? Yes No If yes, explain:

Were there any problems after birth? Yes No If yes, explain:

B. Pre-school/Toddler Temperament: Please check the following items that apply.

Did not enjoy being held	Excessive restlessness	Colic
Feeding problems	Sleep problems	Head-banging
Sensitive to light / noise / texture	Fussy or unhappy	Difficulty bonding

C. Developmental Milestones: Please indicate the approximate age in months when your child achieved the following tasks:

_____ Sitting alone _____ Walking _____ Put words together _____ Toilet trained

D. Unusual behaviors/Speech patterns:

Spinning	Putting things in the mouth	Repeating words or phrases inappropriately
Hand flapping	Sniffing excessively	Saying "I" for "You"

V. School/daycare History:

Did your child attend daycare? Yes No If yes, what was their age? _____
Any problems? _____

What were your child's grades on their last report card? _____
What is the name of your child's primary teacher? _____

Name of Current School: _____

Current Grade Placement: _____

Problems: Yes_____ No _____

Name of **Past Schools**:	Dates Attended	Present Grade Placement	Behavior Problems	Learning Problems
_____	_____	_____	Yes No	Yes No
_____	_____	_____	Yes No	Yes No
_____	_____	_____	Yes No	Yes No

Has your child ever been:
evaluated for a learning disability? Yes No If yes, what grade? _____ When?

Placed in Special Education Classes? Yes No If yes, what type of class? _____

Tested by the school system? Yes No If yes, when? _____

Expelled or suspended? Yes No If yes, please describe: _____

Does your child have a current IEP (Individual Education Plan)? Yes No
Does your child have a current 504 plan? Yes No

VI. Legal / Juvenile Court / Alabama State Department of Human Resources (DHR):

Has your child been: Arrested? Yes No Assigned a probation officer? Yes No
If yes, their name: _____
Jailed? Yes No

Has your child ever appeared in juvenile court? Yes No
or other family member ever been reported to DHR? Yes No
been assigned a DHR caseworker? Yes No
If yes, their name: _____
ever been a victim of child physical or sexual abuse? Yes No
If you answered yes to any of these questions, please explain:

VII. Family Medical History:

Sudden death Heart disease (especially dysrhythmias) Diabetes mellitus

Obesity Narrow Angle Glaucoma Seizures

VIII. Family Psychiatric History:

Has any member of your child's family been treated for depression, bipolar disorder, schizophrenia, anxiety, suicidal thoughts, alcohol or other drug problems, learning disabilities or ADD/ADHD, etc.? Yes No

If yes, please explain:

IX. Social / Family History:

Biological mothers' full name: _____Biologicalfatherullname:_____

Biological parents marital status: Married to each other Divorced Separated

If divorced from one another, has either remarried? Mother Yes No
Father Yes No

If the biological parents are divorced or separated, who has custody of the patient? _____

Type of custody? _____

Stepmothers' name: _____

Stepfathers' name: _____

List all relatives who presently live in the same household as your child (if more than 5 please list on back of this sheet):

Name	Relationship	Type of Employment / Student Grade Level
1.		
2.		
3.		
4.		
5.		

Please circle any of the following stressors that presently affect your child:

Family financial problems	Family relationships	Legal problems
Child rearing problems	Drug or alcohol problems	Abuse behavior
Health problem	Employment problems	School problems
Peer relationships	Frequent change of household	Frequent moves

"Other" problem _____

Please explain how any item you checked affects your child.

Reminder: Please bring a copy of any custody papers to the initial appointment.