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CHILD HISTORY QUESTIONNAIRE

Name: ___________________________________ **Grade:** ________________________

Age: ___________________________________ **School:** ________________________

Person Completing Form: ____

Family History

Parents

With whom does the child live at this time? ____

Are parents divorced or separated? ____

Date of Divorce:_________________________________ If divorced, who has legal custody? ______________________________

If divorced, please describe visitation schedule:____

____

Were the child's parents ever married? ____ Yes ____ No

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? ____________________ Yes ____ No If Yes, describe:

____

____

Client's Mother

Name: _______________________ Age: _____Occupation: _________________Hours worked per week ______

Where employed: ____

Mother's education: ____

Is the child currently living with mother? ____ Yes _______ No

___Natural parent ___Step-parent ___Adoptive parent ___Foster home ___ Other (specify): _____________

Is there anything notable, unusual or stressful about the child's relationship with the mother?__ Yes __ No If Yes, please explain: ____

____

Client's Father

Name: _______________________ Age: _____ Occupation: _______________Hours worked per week: _____

Where employed: ____

Father's education: ____

Is the child currently living with father? __ Yes ____ No

___Natural parent ___Step-parent ___Adoptive parent ___Foster home ___Other (specify): _________

Is there anything notable, unusual or stressful about the child's relationship with the father? __Yes __No

If Yes, please explain:

____

____

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
_________________	____	____ F ____ M	____ home ____ away	___ poor ___ average ___ good
_________________	____	____ F ____ M	____ home ____ away	___ poor ___ average ___ good
_________________	____	____ F ____ M	____ home ____ away	___ poor ___ average ___ good
_________________	____	____ F ____ M	____ home ____ away	___ poor ___ average ___ good
Others living in the household			Relationship (e.g., cousin, foster child)	
_________________	____	____ F ____ M	__________________	___ poor ___ average ___ good
_________________	____	____ F ____ M	__________________	___ poor ___ average ___ good

What languages (other than English) are spoken in the home? ____

Has the child experienced any physical abuse sexual abuse or neglect? ___Yes ___No

If Yes, describe: ____

____

Has the child/adolescent experienced death? (friends, family pets, other) ____ Yes ____ No

At what age? _____ If Yes, describe the child's/adolescent's reaction: ____

____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

___ Yes ____ No If Yes, describe: ____

____

Developmental History

Pregnancy/Birth

Has the child's mother had any occurrences of miscarriages or stillborns? ___Yes ___No

If Yes, describe: ____

Length of pregnancy: ___ Mother's age at child's birth: _____

Did the mother use drugs, cigarettes or alcohol? ____ Yes _____ No If Yes, type/amount: ______________________

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication) __Yes __No

If Yes, describe: ____

Length of labor: ___________ Induced: __ Yes ____ No Caesarean? ____ Yes ____ No

Baby's birth weight: ________________ Baby's birth length: ____________________

Describe any physical or emotional complications with the delivery: ____________________________________

____

Describe any complications for the mother or the baby after the birth: __________________________________

____

Length of hospitalization: Mother: ______________ Baby: ______________

Developmental History

Please note the age at which the following behaviors took place:

Sat alone: ______________________________ Dressed self: ____________________________

Took 1st steps: __________________________ Tied shoe laces: __________________________

Spoke words: ___________________________ Rode two-wheeled bike: ___________________

Spoke sentences: ________________________ Toilet trained-- Day:______Night: _________

Compared with others in the family, child's development was: _____ slow ___________ average _______________ fast

Age for following developments (fill in where applicable) Began puberty:_____Menstruation: _____

Issues that affected child's development (e.g., inadequate nutrition, neglect, etc.)____

____

Medical/Physical Health

Health Conditions

___Abortion ___Hayfever ___Pneumonia ___Asthma ___Heart trouble ___Polio ___Blackouts ___Hepatitis __Pregnancy
___Bronchitis ___Hives ___Rheumatic Fever ___Cerebral Palsy ___Influenza ___Scarlet Fever ___Chicken Pox ___Seizures
___Congenital problems ___Measles ___Severe colds ___Croup ___Meningitis ___ Concussions/Head injury ___Diabetes
___Diphtheria ___Multiple sclerosis ___Thyroid disorders ___Dizziness ___Mumps ___Vision problems ___Ear aches
___Wearing glasses ___Ear infections ___Nose bleeds ___Whooping cough ___Eczema ___Other skin rashes Fevers

List any current health concerns: ____

Current prescribed medications	Dose	Dates	Purpose	Side effects
______________________	_______	_________	____________	______________________
______________________	_______	_________	____________	______________________
______________________	_______	_________	____________	______________________

List dates/reasons of any hospitalizations: ____

Immunization record: Has the child received all immunizations? ___Yes ___No

Name of Physician:____

Is there a family history of mental illness, learning problems, or substance abuse? Please describe: ______________________
____

Nutrition

Does your child eat fruit/vegetables? ___Yes ___No Does your child engage in "emotional eating"? ___Yes ___No

Would you describe your child as a picky eater? ___Yes ___No

Does your child eat meals that are prepared for the entire family? ___Yes ___No

Describe any concerns regarding your child's weight or eating habits: ____________________________________
____

Education

Current school: __________________________Grade: ________Teacher: ______________________________

Type of school: ___Public ___Private ___Home schooled ___Other (specify):_____________________________

In special education? ____ Yes ___ No If Yes, describe: ____

In gifted program? ____ Yes ____ No If Yes, describe: ____

Has your child ever received speech/language therapy? _____ Yes _____ No If Yes, describe: ______________________

Has child ever repeated a grade in school? ____ Yes ___ No If Yes, describe: ____________________________

Which subjects does the child enjoy in school? ____

Which subjects does the child dislike in school? ____

What grades does the child usually receive in school? ____

Have there been any recent changes in the child's grades? ___ Yes ___ No If Yes, describe: ______________________

Has the child been tested psychologically? ____ Yes ____ No Describe:_________________________________

Briefly describe the child's performance and any concerns in each grade:

Kindergarten: ____

1st Grade: ____

2nd Grade: ____

3rd Grade: ____

4th Grade: ____

5th Grade: ____

6th to 8th Grade: ____

High School: ____

What percentage of homework time requires adult supervision? ___________ Average time per night spent on homework________
Check the descriptions which specifically relate to your child.

Feelings about School Work:
___Anxious ___Passive ___Enthusiastic ___Fearful ___Eager ___No expression ___Bored ___Rebellious
__ Other (describe): ____

Approach to School Work:
___Organized ___Industrious ___Responsible ___Interested ___Self-directed ___No initiative ___Refuses ____ Perfectionism
___Does only what is expected ___Sloppy ___Disorganized ___Cooperative ___Doesn't complete assignments
__ Other (describe): ____

Performance in School (Parent's Opinion):
___ Satisfactory ___Underachiever ___Overachiever ___Other (describe):________________________________

Child's Peer Relationships:
__ Spontaneous ___Follower ___Leader ___Difficulty making friends ___Makes friends easily ___Long-time friends
___Shares easily ___Other (describe): ____
If the child is involved in a vocational program or works a job? Describe: ________________________________
Are there any problems?____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, physical fitness, sports, church activities etc.)
____
____

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? ___Yes __ No
If Yes, describe: ____
____

Counseling/Prior Treatment History

	Yes	No	When	Provider's Name	Overall experience
Counseling	____	____	____________	________________	____________________________
Psychiatric	____	____	____________	________________	____________________________
Drug/alcohol treatment	____	____	____________	________________	____________________________
Hospitalizations	____	____	____________	________________	____________________________
Psych. Testing	____	____	____________	________________	____________________________

Additional Comments:____
____

Current Evaluation

Please describe your reasons for having your child tested at this time: ________________________________
____
____

Legal History

Please describe your child's current or past involvement with the legal system: ____________________________
____

Other

Please describe any other concerns you have regarding your child/adolescent: