Today's Date _____ **HEALTH QUESTIONAIRE**

THE CARING TREE
CHILDREN'S COUNSELING CENTER

Please check or circle your concerns.

BEHAVIOR PROBLEMS:

Self-injurious behaviors:

- ☐ Lying/stealing
- ☐ Problems socializing
- ☐ Clingy
- ☐ Rage
- ☐ Physical aggression
- ☐ Refusal to attend school
- ☐ Withdrawn
- ☐ Tearful
- ☐ Nightmares
- ☐ Verbal aggression
- ☐ Alcohol/drug use
- ☐ Other:_____

Emotional Distress:

- ☐ Depression/sadness
- ☐ Moodiness
- ☐ Suicidal/homicidal
- ☐ Death
- ☐ Anger
- ☐ Anxiety
- ☐ Psychotic-like symptoms
- ☐ Parents' divorce
- ☐ Other:_____

FUNCTIONAL PROBLEMS:

- ☐ Poor hygiene
- ☐ Irresponsible
- ☐ Employment
- ☐ Concentration problems
- ☐ Problems with mobility
- ☐ Physical pain/injury
- ☐ High or low energy
- ☐ Poor organization skills
- ☐ Problems with hearing
- ☐ Impulse control
- ☐ Poor grades
- ☐ Unmotivated
- ☐ Problems with speech
- ☐ Social relationships
- ☐ Memory problems
- ☐ Lack of coordination
- ☐ Recognition of danger
- ☐ Sleep problem
- ☐ Learning problems
- ☐ Fine Motor problems
- ☐ Money management
- ☐ Eating problem
- ☐ Cognitive problems
- ☐ Feeding Aversion
- ☐ Safety problems
- ☐ Sensory problems
- ☐ Problems with play
- ☐ Difficulty chewing/swallowing
- ☐ Other: _____

DEVELOPMENTAL HISTORY

Mother's age at time of the child's birth: _____

Was this patient possibly exposed to alcohol or other substances during mother's pregnancy? Yes No

What were the complications or concerns during the pregnancy for the mother? None

(If any of the following occurred, please elaborate on the condition and treatment.)

- ☐ Gestational diabetes
- ☐ Anemia
- ☐ Preeclampsia
- ☐ Placenta previa
- ☐ Toxemia
- ☐ Depression
- ☐ Sexually transmitted disease
- ☐ Heart disease
- ☐ Physical trauma
- ☐ Premature labor
- ☐ Abuse
- ☐ Other:_____

Prescribed medications during pregnancy: _____

_____

Was bed rest required? No Yes

If yes, please describe length of time and reason. _____

_____

Length of Pregnancy Full term Premature – born at how many weeks? _____ **Birth weight** _____

Place of Birth Hospital *Name*:_____ Home Other: _____

Was labor induced? No Yes, please describe the reason: _____

Length of labor: _____ Length of time pushing: _____

Mode of delivery: Vaginal Cesarean Emergency Cesarean

How many days was this patient hospitalized after birth? _____

Patient's Name _____ DOB _____

Patients Name _____ DOB _____

Were there any concerns or complications during or immediately after delivery?

- ☐ Baby's heart rate dropped
- ☐ Cord wrapped around neck
- ☐ Born "blue"
- ☐ Breech
- ☐ Low blood sugar
- ☐ Low Apgar scores
- ☐ Significant jaundice (bilirubin)
- ☐ IV fluids
- ☐ Difficulty sucking
- ☐ Oxygen
- ☐ Other: _____
- ☐ Treatment in the NICU/special care unit – details: _____

Temperament as an infant: Easy Withdrawn Difficult Other: _____

Bonding: Cuddly Withdrawn Clingy Other: _____

Activity level as an infant and toddler: Average On-the-go Destructive Lethargic Accident prone

Apprehension with strangers: Mild Moderate Severe None

Emotionally oversensitive/over-reactive as an infant: No Yes

If yes, does this continue to be a problem? No Yes

DEVELOPMENTAL MILESTONES Check all that apply.

By 2-4 Weeks:

- ☐ Can sleep for 3 or 4 hours at a time; On stomach, lifts head momentarily; When crying, can be consoled by being spoken to or held
- ☐ Responds to parent face/voice; Can stay awake for >1 hour of the time

By 2 Months:

- ☐ Coos/vocalizes; Lifts head, neck, and upper chest
- ☐ Smiles responsively w/support of forearms from stomach

By 9 Months:

- ☐ Responds to name; Crawls, creeps, or scoots; Pokes with fingers, shakes, bangs,
- ☐ Understands a few words; Sits unsupported throws, drops objects
- ☐ Babbles; Plays peek-a-boo or pat-a-cake; Feeds self with fingers

By 12 Months:

- ☐ Pulls to stand and may; Says 2-4 words, imitates vocalizations; Waves "bye-bye"; takes a few steps alone; Looks for dropped or hidden objects; Feeds self
- ☐ Drinks from cup; Steps while holding on; Brings toys/objects to show

By 18 Months:

- ☐ Walks backward; Uses two-word phrases; Follows simple directions
- ☐ Throws ball; Uses a spoon and cup; Points to some body parts
- ☐ Scribbles; Shows affection, kisses; Pulls a toy along the ground
- ☐ Watches face for reaction

By 24 Months:

- ☐ Goes up and down stairs; Stacks five blocks; Follows two-step commands one step at a time; Uses at least 20 words; Imitates adults
- ☐ Kicks ball two-word phrases

By 5 Years:

- ☐ Dresses self without help; Can count on fingers; Recognizes most letters and prints some
- ☐ Learns address/phone number; Copies basic shapes; Speech is easily understood

By 11-18 Years:

- ☐ Sexual development; Peer relationships; Social/emotional interaction and behaviors; Worries about grades

Toilet trained? Yes No

Circle all that apply: Daytime wetting Nighttime wetting Bowel incontinence

Patients Name _____ DOB _____

Puberty: No Yes, started at age: ____ If female, first menstruation age: _____

Cares for self (i.e. Bathing, Dressing, And Grooming): Yes No With help

Other Notes: _____

_____

MEDICAL HISTORY

Name of Primary Care Physician & Clinic Name: _____

Date of last physical exam: _____

Major Surgeries (attach additional information if needed) Procedures & Complications

1. _____
2. _____
3. _____

Medical Hospitalizations (attach additional information if needed):

1. _____
2. _____
3. _____

Medical Diagnoses: _____

_____

Has this patient ever experienced the following? Check all that apply.

- ☐ High fever requiring hospitalization or treatment
- ☐ Unexplained fever or spike of temperature
- ☐ Head injury
- ☐ Concussion
- ☐ Loss of consciousness
- ☐ Tics or abnormal body movements
- ☐ Thyroid or endocrine problems
- ☐ Strep throat
- ☐ Chronic ear/sinus infections. Were tubes required? No Yes
- ☐ Seizures Type: Partial Partial complex Generalized
  Beginning at what age: _____ Frequency: _____
- ☐ Diabetes/blood sugar problems
- ☐ Meningitis, encephalitis
- ☐ Bronchitis, pneumonia
- ☐ Upper respiratory problems/asthma
- ☐ Allergies
- ☐ Other congenital conditions: _____
- ☐ Lead or other toxin exposure: _____

Current Medications	Dose (mg, mL, IU)	Frequency Prescribed	Frequency Actually Taken	Date Started	Reason

Patients Name _____ DOB _____

Past medications that produced ineffective or negative reactions	Dose (i.e mg, mL, IU)	Frequency Prescribed	Frequency Actually Taken	Dates Taken	Reason Prescribed/Stopped

Current Medical Conditions/Illnesses *Circle all that apply.*

Hearing: No problem Conductive impairment Sensory-neural impairment Hearing devices

Vision: No problem Nearsighted Farsighted Glasses Contacts Blind Other:_____

Speech: No problem Does not speak Speaks words, no sentences Words difficult to understand Stutters

Sleeping

- ☐ Duration in hours: _____
- ☐ Requires naps
- ☐ Midnight awakening
- ☐ Nightmares Frequency: _____ Content:_____
- ☐ Early awakening
- ☐ Difficulty falling asleep
- ☐ Other: _____

Eating

- ☐ No problems
- ☐ Obsessed with food – Since when? _____
- ☐ Increased/decreased appetite – Since when? _____
- ☐ Drooling
- ☐ Food falls from mouth
- ☐ Gags
- ☐ Eats limited types of food
- ☐ Has taste/texture sensitivities

Weight gain/loss: Amount and timeframe: _____

PSYCHIATRIC HISTORY

Psychiatric hospitalization(s)

1. When and where? _____
2. When and where? _____

Has the child been diagnosed previously with any type of developmental conditions?

☐ **ADHD/ADD**

Date of diagnosis: _____Type:_____ By whom:_____

☐ **Autistic spectrum disorder** Circle one: Autism PDD NOS

Date of diagnosis: _____By whom:_____

☐ **Cognitive impairment** Circle one: Mild Moderate Severe mental retardation

Date of diagnosis: _____By whom:_____

☐ **Receptive / expressive / mixed speech delay Circle one**

Date of diagnosis: _____By whom:_____

☐ **Learning Disability** Date of diagnosis: _____By whom:_____

☐ **Other Mental Health Diagnoses**

Diagnosis: _____Date of diagnosis: _____By whom:_____

Diagnosis: _____Date of diagnosis: _____By whom:_____

Patients Name _____ DOB _____

Allied Health Professionals

Past mental health professional(s) (Psychologist, Psychiatrist, Neurologist, or other). Please include Name, Time Frame - Dates of Treatment _____

_____

Ever had psychological or neuropsychological testing? Yes No

If yes, by whom and when? _____

Current mental health professional(s) (Psychologist, Psychiatrist, Neurologist, or other) Please include Name and Dates: _____

_____

SUBSTANCE ABUSE

Please indicate any substance used currently or in the past by the child or parent:

		Alcohol	Marijuana	Ecstasy	Huffing	Other, specify:
Child	Current					
	Past					
Mother	Current					
	Past					
Father	Current					
	Past					

Has the child ever attended a substance abuse treatment program? No Yes

FAMILY **Current Living Situation**

- ☐ Biological parents (married or cohabitating)
- ☐ Biological parents (divorced/separated) ☐ with visitation ☐ without visitation
- ☐ Biological mother and stepfather/parent partner ☐ with visitation ☐ without visitation
- ☐ Biological father and stepmother/parent partner ☐ with visitation ☐ without visitation
- ☐ Foster or adoptive family
- ☐ Other: _____

Family & other Household Members. List **all immediate family members** and any person who lives in the childs home.

Relationship	**Name**	**Living in Home**? Y or N	**Age**	**Quality of Relationship**		
				Good	Fair	Poor
Mother						
Father						

Patients Name _____ DOB _____

FAMILY HISTORY QUESTIONS Does anyone on either the mothers side or fathers side of the family have had or are suspected to have had difficulties with any of the following: Please check all those which apply.

	Mothers Side (Who & What)	Father's Side (Who & What)
Attention		
Learning Difficulties		
School Problems		
Behavior Problems		
Depression		
Anxiety		
PTSD		
Drug/Alcohol Abuse		
Legal Issues		
Hallucinations/Delusions		
Bipolar/Depression		
Eating		
Epilepsy		
Mental Retardation		
Dementia or Alzheimers		
Traumatic Brain Injury		
Autism		
Heart or lung problems		
Speech/Language Problems		
Genetic Disorders		

Significant Trauma (include age at time of incident, nature of trauma, and any legal details)

☐ Injured in an accident: _____

☐ Physical abuse (child was the victim or perpetrator): _____

☐ Sexual assault/abuse (child was the victim or perpetrator): _____

☐ Emotional abuse (child was the victim or perpetrator): _____

☐ Neglect: _____

☐ Removed from home (Foster care Residential Treatment Parent or other): _____

SOCIAL RELATIONSHIPS

What words best describe the child?

☐ Friendly	☐ Withdrawn	☐ Shy
☐ Popular	☐ Socially awkward	☐ Few friends
☐ Leader	☐ Socially "clueless"	☐ No friends
☐ Used to have more friends	☐ Interested in friends	☐ Not interested in friends

How did the child adjust to:

Social demands of preschool/kindergarten (e.g., group activities, sharing, playing with other children, etc.)?

_____

Losses/separations (deaths, moves, etc.):_____

Extracurricular activities/religious participation: _____

Patients Name _____ DOB _____

DISCIPLINE

Physical:
☐Spanking
☐Other: _____

Non-physical:
☐Time outs
☐Yelling/screaming
☐Taking things away
☐Praise
☐Other: _____

Child's response to discipline: _____

PERSONAL INFORMATION

What are the child's greatest strengths/attributes? _____

_____

Hobbies/Interests _____

_____

LEGAL Please detail any contacts the child has had with the courts, police, etc. _____

_____

EMPLOYMENT Yes OR No employment history due to age

Was the child ever employed? Yes No

Was the child successful at job? Yes No – details: _____

Was the child ever fired? No Yes – details:_____

Jobs held:_____

Household chores:_____

ACADEMIC Current school:_____

Started school at what age: _____ Current grade: _____

Participated in: Title I reading Developmental kindergarten Early childhood education Birth to 3

Has the child utilized Special Education support services? No Yes, IEP OR 504 Plan

Please specify below all classifications that have been used, and *circle the current classification*.

☐ Cognitively impaired
☐ Emotionally impaired
☐ Hearing impaired
☐ Visually impaired
☐ Other health impairment
☐ Severe multiple impairment
☐ Speech and language impairment
☐ Learning disabled
☐ Physical disability

Academic Performance:

☐ Consistently above average (A's, B's) OR Consistently average (B's, C's)
☐ Consistently below average (C's, D's) OR Consistently below average to failing (C's, D's)
☐ Previously strong grades, recent deterioration: OR Previously weak grades, recent improvement
☐ Dropped out of school. At what age and grade? _____
☐ Graduated from high school. Obtained: GED or Regular diploma or Special education certificate

Was child ever:

☐ Held back – What grades? _____
☐ Suspended – For what and for how long? _____
☐ Expelled – From what grade and why? _____

Patients Name _____ DOB _____

☐ Home schooled – When and why?_____

Additional information you would like to let the provider know: _____

_____

_____

Who completed this form? _____ Today's Date: _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Therapist Review Signature: _____ Date:_____