# CHILD QUESTIONNAIRE
**AGES 0-12**

**Name of Client**_____

**Date of Birth**_____**Age**_____

**Address of Client**_____

**Legal Guardian Name/s**_____

## Your Child's Birth History

1. Is your child **adopted**? YES NO If so, at what age? _____ Where was your child born? _____
2. Was your child **born**: FULL-TERM PREMATURE If premature how many weeks? _____
3. Was the **pregnancy planned**? YES NO
4. Please check any of the following which occurred during pregnancy:

| | | | |
|---|---|---|---|
| ___Prenatal care | ___Good Nutrition | ___Accident | ___Chronic disease |
| ___Nervous/Worried | ___Headaches | ___Measles | ___Over/Underweight |
| ___Unusual stresses | ___Medications taken | ___Toxemia | ___Narcotics/alcohol intake |
| ___Vomiting/Nausea | ___Flu/high fevers | ___Infections | |

5. Did your **child's mother** smoke tobacco or use any alcohol, drugs or medications during the pregnancy? YES NO
6. If so, please lists which ones: _____
7. Did the child's **mother have any problems** during the pregnancy or at delivery? YES NO If so, please describe them:

_____

_____

8. How well do you believe that **mother and baby bonded** after baby's birth? _____
9. **Developmental milestones:** Please rate child on EACH of the following, using a scale of: A=average; S=slower than average; F=faster than average

| | | | | |
|---|---|---|---|---|
| _____ Smiled | _____Sat up without support | _____Stood_ | ____ Walked | _____Fed self |
| _____ Said 1st word | _____Said phrases | _____Toilet Trained | _____Dressed self | |

10. Please explain any **milestone rated other than A** (average): _____

_____

_____

11. During the child's first year of life, was **anything present in the life of the mother or father** which caused unhappiness or anxiety, or which placed either parent under special strain (even if the event had nothing to do with the baby)? If so, please explain.

_____

## About Your Child's Family

1. The name of the child's **biological parents**: Mother _____Father: _____
2. **Marital status** of biological parents: _____ Who has **legal guardianship** of your child? _____
3. **Primary language(s)** spoken in child's home: _____ Child's **Ethnicity**: _____
4. Please describe any **past counseling** that either your child or family member has had: _____

5. Please **list family members.**

| Relatives | Name | Age/Education | Does Child Get Along Well with this Person? | Grade/ Occupation |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Brother(s) | | | | |
| Sister(s) | | | | |
| Step-Father | | | | |
| Step-Mother | | | | |
| Step-Brother(s) | | | | |
| Step-Sister(s) | | | | |
| List all people who live in the home with this child | | | | |

6. In **your family, including yourself**, was there:
**Alcoholism?** Yes No Father / Mother / Siblings / Self How Long?_____
Resolved?:_____

7. **Substance Abuse?** Yes No Father / Mother / Siblings / Self How Long?_____
Resolved?:_____

8. **Mental Illness?** Yes No Father / Mother / Siblings / Self How Long?_____
Resolved?:_____

9. **Serious Illness?** Yes No Father / Mother / Siblings / Self How Long?_____
Resolved?:_____

10. List **major changes,** including marriages, divorces, moves, deaths. etc, which have occurred in your family in the last 5 years. (If there are other events that happened earlier that still affect the family, please add those.)

11. **Who can you depend on** when you need help? (Please include any church or community programs.)

12. What **stresses** does your family struggle with?_____

13. How often does your family have **dinner together**?_____

14. How many **holidays** does your family spend together?_____

15. How often, and what **activities** do you do together as a family (church, sports, etc)?_____

16. Are there any cultural influences I should be aware of?_____

## About Your Child's Education

1. What **school** does your child currently attend? _____

Address: _____

Phone: _____ **Teachers Name:** _____

2. Current **Grade:** _____ Has your child ever **repeated a grade**? YES NO If so, which one(s)? _____

3. How many classes did your child A) fail last year?_____ B) failing now?_____

4. Child's **Favorite** Class/Subject_____ **Least favorite** Class/Subject_____

5. Has your child ever received **special education services**? If yes, please elaborate (under what classification): _____

_____

6. Has your child received any academic or psychological **testing** done at school or elsewhere? Yes No If yes, when and where?

_____

7. What do school **teachers/personnel tell you** about your child? _____

_____

8. Has your child experienced any of the following **problems at school**? (Circle all that apply):

___fighting ___lack of friends ___drug/alcohol ____detention
___suspension ___learning disabilities ___poor attendance ____poor grades ___gang influence ___incomplete homework ___behavior problems ____emotional problems

9. **Please Complete.**

| Grade | School | Avg. Grades | City | State |
|---|---|---|---|---|
| Pre-K | | | | |
| K | | | | |
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |

## About Your Child's Routine

1. What kinds of **physical exercise** does your child get? _____
2. How much coffee, cola, tea, or other **caffeine** does your child consume each day? _____
3. Is your child's **eating restricted** in any way? How? Why? _____

_____

_____

4. **Bedtime:** _____ **Wake-up Time:** _____ **Hours of sleep** on an average night: _____
5. Does your child have any **problems getting enough sleep**? YES NO Please describe fully. _____

_____

6. **Curfew:** A) school nights_____ B) weekend/holiday nights_____
7. List assigned **chores** and how well they do them_____

_____

8. Describe the **discipline** program you use at home._____

_____

9. Do the adults in the home **agree** on the use of this discipline program?_____
10. What does your child currently **do too often**, too much, or at the wrong times, that gets him/her in trouble? Please list all the behaviors you can think of. _____

_____

_____

11. What does your child **fail to do**, as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of. _____

_____

_____

12. What does your child **do that you like**? What does he/she do that other people like? _____

_____

_____

## About Your Child's Health

1. Who is your child's **pediatrician**? _____When was the last visit? _____

Address: _____ Phone: _____

2. Any **concerns** shared by the doctor? _____

3. Has your child experienced any of the following **medical problems**? ___a serious accident ___hospitalization

___surgery ___asthma ___a head injury ___high fever ___convulsions/seizures

___eye/ear problems ___meningitis ___hearing problems ___allergies

___loss of consciousness ___other _____

4. Describe any **allergies** your child has: _____
5. List all **medications or drugs** your child takes or has taken in the last year—prescribed, over-the-counter, and others. Include dosages please_____

_____

_____

_____

6. What nutritional **supplements or herbs** is your child taking?_____

_____

## Your Child's Social Information

1. Please describe any past or current **traumas** your child has experienced (including abuse, physical sexual or verbal): _____

_____

_____

2. Please describe your child's **interaction with adults**: _____

_____

3. Please describe your child's **interaction with other children**: _____

_____

4. **How many** of your child's peers can you describe? ___None ___Some ___Most ___All
5. Do **you like** your child's peers? ___None ___Some ___Most ___All
6. Have any of your child's friends been **in trouble** with the law? ___None ___Some ___Most ___All
7. How would you describe your child's **personality and/or temperament** (happy, content, fussy, quiet, irritable)? _____

_____

8. Please include any **additional information** that you feel is important regarding your child: _____

_____

_____

## Your Child's Treatment History & Goals

1. Has your child received **previous psychiatric treatment** or counseling? YES NO If yes, please list previous mental health professionals, dates of treatment, diagnosis (ses), and treatment effectiveness. _____

_____

2. Has your child ever made statements of **wanting to hurt him/her self** or seriously **hurt someone else**? Has he/she ever purposely hurt himself or another? YES NO If yes to either question please describe the situation: _____

_____

3. Has your child ever experienced any serious **emotional losses** (such as a death of or physical separation from a parent or other caretaker)? YES NO If yes, please explain: _____

_____

4. Has anyone in your family been diagnosed with a **developmental or learning problem** (including autism, mental retardation, genetic disorders)? YES NO If yes, please explain: _____

_____

5. Has anyone in your child's **family been diagnosed** with a psychiatric illness (anxiety, depression, suicide, schizophrenia)? YES NO If yes, please explain: _____

_____

6. What is your **main concern**?_____

_____

7. What do you think **causes** this problem?_____

_____

8. How have you **tried to solve** this problem?_____

_____

9. From your preceding list of your child's behavior and your family concerns, what problem behaviors do you **want to see change FIRST**: and how much must they change for you to be **satisfied**? _____

_____

_____

10. Are there any risk factors with your child? (self abusing behaviors, suicidal thoughts, statements, etc).

_____

_____

_____

_____

**11.** Any **additional information** that you would like to share?

# Risk Assessment

SUICIDE/HOMICIDE

Have you **ever had** or **do you have**? Check all that apply.

| | Past | Now |
|---|---|---|
| Thoughts of hurting yourself? | | |
| Thoughts of committing suicide? | | |
| Plans to commit suicide? | | |
| Attempts to commit suicide? | | |
| Threats to commit suicide? | | |
| Thoughts of harming someone? | | |
| Plans to harm someone? | | |
| Attempts to harm someone? | | |
| Threats to harm someone? | | |
| Actually harmed someone? | | |

DEPRESSION

Have **you ever** or **do you now have**? Check all that apply.

| | Past | Now |
|---|---|---|
| Inability to sleep or sleeping longer? | | |
| Increased or decreased appetite? | | |
| Tearfulness or feelings of despair? | | |
| Lack of energy or feelings of fatigue? | | |
| Preoccupation with life events? | | |
| Decreased contact with others? | | |
| Feelings of depression? | | |
| Decreased interest in pleasurable activities | | |

Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper: