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Licensed Clinical Psychologist

CHILD & ADOLESCENT QUESTIONNAIRE (Ages 17 and under)

(To be filled out by Parent/Guardian)

Child's Name: _____ Today's Date: _____

Birthdate: _____ Age: _____ Sex: Male Female

Home Address: _____

Name of Person Completing Form: _____

Relationship of Person to Child: _____

Mother's Name & Address: _____

Father's Name & Address: _____

Steparent's Name & Address: _____

Relationship Status of Parents: Married Divorced Remarried Never Married Other

School: _____ Grade: _____

School District: _____

Pediatrician/Physician: _____ Phone of Physician: _____

Address of Physician: _____

If necessary, I give Dr. Schram permission to call me at the following numbers:

Home _____ OK to leave a message: Y N

Mother's Work _____ OK to leave a message: Y N

Name of Mother's place of employment: _____

Mother's Cell _____ OK to leave a message: Y N

Father's Work _____ OK to leave a message: Y N

Name of Father's place of employment: _____

Father's Cell: _____ OK to leave a message: Y N

Other: _____ OK to leave a message: Y N

Email: _____ OK to email: Y N

Name of person responsible for bill: _____

Who referred your child to my office: _____

May I have your permission to thank this person for the referral: ___Yes ___No

List all people living in household:

Name	Relationship to Child	Age	Grade/Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Siblings living outside home: (names/ages) _____

Primary language spoken in the home: _____

Other languages spoken in the home: _____

Race/Ethnicity/Religion: _____

Why are you seeking professional assistance for your child at this time? Briefly describe your child's current difficulties: _____

How long has this problem been a concern: _____

When was it first noticed: _____

What seems to help the problem: _____

What seems to make it worse: _____

Has the child ever received evaluation or treatment for the problem or a similar problem: _____

If yes, when and with whom: _____

Is the child on any medication at this time (please list kind and dosage): _____

Checklist of Concerns About Your Child:

- | | |
|--|--|
| <input type="checkbox"/> Angry | <input type="checkbox"/> Frequent Ear infections |
| <input type="checkbox"/> Argues, talks back, defiant | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Bullies, intimidates, bossy | <input type="checkbox"/> Hypochondriac, always feels sick |
| <input type="checkbox"/> Cheats | <input type="checkbox"/> Immature |
| <input type="checkbox"/> Cruel to animals | <input type="checkbox"/> Imaginary Playmates |
| <input type="checkbox"/> Conflicts with parents | <input type="checkbox"/> Interrupts |
| <input type="checkbox"/> Complains | <input type="checkbox"/> Lacks organization |
| <input type="checkbox"/> Compulsions | <input type="checkbox"/> Language problems |
| <input type="checkbox"/> Coordination problems | <input type="checkbox"/> Lacks respect for authority |
| <input type="checkbox"/> Cries easily, feelings easily hurt | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Dawdles, wastes time | <input type="checkbox"/> Legal difficulties |
| <input type="checkbox"/> Difficulties with new marriage/new family | <input type="checkbox"/> Likes to be alone, withdraws |
| <input type="checkbox"/> Dependent, immature | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Developmental delays | <input type="checkbox"/> Low frustration tolerance, irritability |
| <input type="checkbox"/> Disruptive | <input type="checkbox"/> Mental retardation |
| <input type="checkbox"/> Disobedient, uncooperative, noncompliant | <input type="checkbox"/> Moody |
| <input type="checkbox"/> Distractible, inattentive, poor concentration | <input type="checkbox"/> Mute, refuses to speak |
| <input type="checkbox"/> Dropping out of school | <input type="checkbox"/> Nail biting |
| <input type="checkbox"/> Drug or alcohol use | <input type="checkbox"/> Nervous, anxious |
| <input type="checkbox"/> Eating difficulties | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Exercise problems | <input type="checkbox"/> Obsessional thoughts |

- ___ Overactive, hyperactive, restless, fidgety
- ___ Recent move, new school, loss of friends
- ___ Risk taking
- ___ Rocking or repetitive movements
- ___ Runs away
- ___ Sad, unhappy
- ___ School failure
- ___ Self-harming behaviors
- ___ Separation difficulties
- ___ Sleep problems
- ___ Speech difficulties
- ___ Sexual issues
- ___ Shy, timid
- ___ Staring spells
- ___ Stubborn
- ___ Suicidal thoughts or attempt
- ___ Temper tantrums
- ___ Thumb sucking, finger sucking, hair chewing, hair pulling
- ___ Tics—involuntary rapid movements, noises, or word productions
- ___ Teased, picked on
- ___ Truant
- ___ Underactive, slow moving, low energy
- ___ Weight/Body image concerns
- ___ Wetting or soiling the bed or clothes
- ___ Worry, fearful

What are your goals and expectations for treatment for your child: _____

Educational History (Please describe any that apply):

Difficulty with reading _____

Difficulty with writing _____

Difficulty with spelling _____

Difficulty with arithmetic _____

Is your child in a special education class: _____

Has your child been held back a grade: _____

Has your child received special tutoring or therapy in school: _____

Developmental History (Please fill in any information you have on the areas below):

Pregnancy and delivery:

Prenatal medical illnesses and health care: _____

Was the child premature: _____

Any birth complications or problems: _____

C-section: _____

Early months of life:

___ Breast fed ___ Bottle fed

If breastfed, for how long: _____

Any allergies: _____

Feeding problems: _____

Sleep patterns or problems: _____

Personality (easy/difficult to soothe, quiet, active, etc.): _____

Milestones(Please list ages):

Rolled over _____

Sat without support _____

Crawled _____

Walked without support _____

Spoke first word _____

Put several words together _____

Fed self _____

Dressed self _____

Toilet trained _____

Stayed dry at night _____

Rode tricycle _____

Began to read _____

Medical History:

Please list all significant childhood illnesses, hospitalizations, head injuries, surgeries, diseases, seizures/convulsions, and other medical conditions.

Condition	Age	Treated by whom	Consequences
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Family History: (Please indicate which family member)

Anxiety _____

Bipolar _____

Depression _____

ADHD _____

Learning Disability _____

Mental Retardation _____

Substance Abuse _____

Suicide _____

What are your child's favorite activities/hobbies:

What activities does your child like the least:

Which disciplinary techniques do you usually use when your child behaves inappropriately:

Ignore problem behavior

Tell child to sit in time out

Scold child

Spank child

Threaten child

Take away a privilege, activity, toy, food

Reason with child

Don't use any technique

Send child to room

Redirect child's interest

Other

Which discipline techniques are effective:

Which are ineffective:

Is there anything else that does not appear on this form that would be important for me to know:

