Child/Adolescent History Questionnaire

Name of the child: ______________________________ Date: ______________
Person Completing Form: ______________________

Please answer the following questions to help us learn about your child's background. Feel free to use the backside of each page if you need more room.

1. Why are you requesting services at this time?

2. Does your child have any stepparents? Yes____ No____
   Please list their name(s):______________________________________
   Would you want your therapist/doctor to communicate with them?
   Yes____ No____

3. What is their current teacher's name?___________________________

4. Please list all the schools your child has attended, any special services they received or behavioral problems they had.

Please answer these questions about health problems of your child and family members.

Child Yes	Child No		Family Member Has Yes
_____	_____	Allergies	_____
_____	_____	Diabetes	_____
_____	_____	Hypertension	_____
_____	_____	Cancer	_____
_____	_____	ADHD	_____
_____	_____	Hearing Loss	_____
_____	_____	Epilepsy/Seizures	_____
_____	_____	Asthma	_____

____	____	Heart Disease	____
____	____	Stroke	____
____	____	Lung Disease	____
____	____	Migraines	____
____	____	Arthritis	____

Describe any other conditions: ______________________________

5. Were there any concerns for your child during your pregnancy or their birth?

6. Please check any concerns in the following areas:

Past	Present	
____	____	Activity level
____	____	Coordination
____	____	Crawling
____	____	Walking
____	____	Talking
____	____	Toilet Training
____	____	Soiling
____	____	Sleeping
____	____	Nightmares/Night Terrors
____	____	Appetite
____	____	Fire starting
____	____	Cruelty to animals
____	____	Bedwetting
____	____	Fear/Anxiety
____	____	General behavior
____	____	General mood
____	____	Aggression
____	____	Physical
____	____	Psychological
____	____	Social
____	____	Intellectual
____	____	Academic
____	____	Suicidal feelings
____	____	Physical abuse
____	____	Sexual abuse
____	____	Emotional abuse

7. Who is your child's physician?______________________________

8. Is your child on any medications? If yes, please list them below.

Name	Dose	How long has been on	Prescribed by

9. Has you child been on any medications in the past you feel are relevant to our services? Yes____ No____ If yes, please list.

10. Please list any parties who are involved in your child's care (e.g., DHS, Juvenal Court, etc.)

NOTE: Your therapist/doctor will ask you to sign a Release of Information form if they need to communicate with any of the people listed on this form.