History Questionnaire - Child or Adolescent

Please take time to fill out this form for your child. This will aid greatly in providing appropriate therapeutic care for them.

Name of Child: ___________________________ DOB: ___________________________

BIRTH HISTORY

Pregnancy

Which of the mother’s pregnancies was this? (1st, 2nd, etc.)

☐ Yes ☐ No
Has the mother had any miscarriages

☐ Yes ☐ No
Any previous premature babies?

Length of pregnancy in weeks (most babies are born 38-42 weeks)

☐ Yes ☐ No
Illness/Infection/Accident during pregnancy? Describe:

☐ Yes ☐ No
Medication during pregnancy Describe:

☐ Yes ☐ No
Was this a planned pregnancy? Describe:

☐ Yes ☐ No
Depression/Stress during pregnancy? Describe:

☐ Yes ☐ No
Alcohol use during pregnancy? Describe:

☐ Yes ☐ No
Smoke cigarettes during pregnancy? Describe:

☐ Yes ☐ No
Drug use during pregnancy? Describe:

Labor and Delivery

☐ Yes ☐ No
Induced?

☐ Yes ☐ No
Labor lasted more than 12 hours?

☐ Yes ☐ No
C-Section? If yes, reason:

☐ Yes ☐ No
Anesthesia? If yes, type: ☐ Spinal ☐ Epidural ☐ General (Asleep)

☐ Yes ☐ No
Any complications with labor or delivery? Describe if yes:

Birth Weight

lbs oz

☐ Yes ☐ No
Breastfed?

How many days spent in the hospital?

Infancy

☐ Yes ☐ No
Enjoyed cuddling?

☐ Yes ☐ No
Fussy, Irritable

☐ Yes ☐ No
More active than other babies?

☐ Yes ☐ No
Sleeping difficulties

☐ Yes ☐ No
Colic?

☐ Yes ☐ No
Eating difficulties

Briefly describe your child as a toddler:

DEVELOPMENTAL HISTORY

As best you can recall, record the age at which your child reached the following developmental milestones. If you cannot recall, check the appropriate box.

Milestone: Age: Best recollection if exact age is not recalled:

Sat without support

Crawled

Stood without support

Walked without assistance

Throw Ball

Spoke first words

(continued) Milestone: Age: Best recollection if exact age is not recalled:
Spoke phrases
Spoke sentences
Bowel trained
Bladder trained, day
Bladder trained, night
Tied shoelaces

List any childhood illnesses, serious accidents, or hospitalizations:
Age at time of incident: Describe incident:

☐ Yes ☐ No History of head injury or loss of consciousness Describe:
☐ Yes ☐ No History of seizures Describe:
☐ Yes ☐ No Allergies Describe:
☐ Yes ☐ No Current health problems Describe:
☐ Yes ☐ No Current infectious disease(s) Describe:
☐ Yes ☐ No Current medications
   Name of medications:
   Dose/frequency:

Additional comments:

Describe your child in the following areas:
Sleeping habits:
Eating habits:
Energy level:

☐ Yes ☐ No Does your child or anyone living with you have an infectious disease? If yes, what?

Current height of your child: _____ ft _____ inches Current weight of your child: _____ lbs

☐ Yes ☐ No Does your child have any health related problems? If yes, explain:

Parents’ current marital status:
☐ Married to each other for _____ years ☐ Mother involved with someone
☐ Separated for _____ years ☐ Father involved with someone
☐ Divorced for _____ years ☐ Mother deceased for _____ years
☐ Mother remarried _____ times Child’s age at time of mother’s death: __________
☐ Father remarried _____ times Child’s age at time of father’s death: __________
☐ Father deceased for _____ years

List any other people living in your home at this time:
Name: ___________________________ Age: _______ Relationship to child: ___________________________
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Name: ___________________________ Age: _______ Relationship to child: ___________________________
Name: ___________________________ Age: _______ Relationship to child: ___________________________

List other important family members or relatives living outside the home:
Name: ___________________________ Age: _______ Relationship to child: ___________________________
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Name: ___________________________ Age: _______ Relationship to child: ___________________________
Name: ___________________________ Age: _______ Relationship to child: ___________________________

Which of the following describes your child’s current living situation?

- Rent apartment
- Rent house
- Own house
- Foster care
- Condominium
- Shelter
- Homeless
- Group home
- Residential treatment

What is the primary language spoken in your home? ____________________________________________
Mother’s current employer/job title: __________________________________________________________
Father’s current employer/job title: ___________________________________________________________

**FAMILY HISTORY**

List the places your child has lived since birth, the dates they lived there, and with whom:

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<th>Where:</th>
<th>_with whom:</th>
<th>Dates (from-to):</th>
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Have your child ever experienced any of the following?

- [ ] Yes [ ] No Physical Abuse Age/Describe: ____________________________________________
- [ ] Yes [ ] No Sexual Abuse Age/Describe: ____________________________________________
- [ ] Yes [ ] No Assault Age/Describe: ____________________________________________
- [ ] Yes [ ] No Death of a parent Age/Describe: _______________________________________ 
- [ ] Yes [ ] No Death of a relative Age/Describe: _______________________________________
- [ ] Yes [ ] No Death of a friend Age/Describe: ________________________________________
- [ ] Yes [ ] No Parental separation Age/Describe: ______________________________________

**FAMILY HISTORY**

Please describe on both parents’ side of the family any history of mental illness, suicide, legal problems, chemical abuse or dependency and physical/sexual abuse.
If it is someone else, describe his or her relationship to you (i.e. paternal uncle- alcoholic, mother- depression, etc):

**Mother’s side of the family:**

- [ ] Yes [ ] No Alcohol abuse If yes, whom? ______________________________________________
- [ ] Yes [ ] No Substance abuse If yes, whom? ____________________________________________
- [ ] Yes [ ] No Mental Health problems If yes, whom? __________________________________
- [ ] Yes [ ] No Physical abuse If yes, whom? ___________________________________________
Sexual abuse

Father’s side of the family:

Alcohol abuse

Substance abuse

Mental Health problems

Physical abuse

Sexual abuse

Other issues currently affecting family members:

Health problems

Disabilities

Legal issues

Financial concerns

CHEMICAL HEALTH

Are you aware of or do you suspect any chemical use by your child?

Cigarettes

Alcohol

Marijuana

Inhalants

Methamphetamines

Cocaine/Crack

Acid/LSD

Other

Previous chemical use problems

Previous chemical dependency treatment

Describe the parental use of drugs or alcohol at this time:

MOTHER

Cigarettes

Alcohol

Marijuana

Inhalants

Methamphetamines

Cocaine/Crack

Acid/LSD

Other

Previous chemical use problems

Previous chemical dependency treatment

FATHER

Cigarettes

Alcohol

Marijuana

Inhalants

SFT, CRS, CTSS, IHT, OP, BP

History Questionnaire- Child or Adolescent

Rev. 05-2015
☐ Yes ☐ No   Methamphetamines   Describe:  
☐ Yes ☐ No   Cocaine/Crack   Describe:  
☐ Yes ☐ No   Acid/LSD   Describe:  
☐ Yes ☐ No   Other   Describe:  
☐ Yes ☐ No   Previous chemical use problems   Describe:  
☐ Yes ☐ No   Previous chemical dependency treatment:   Describe:  

SCHOOL
Name of the school your child attends: ____________________________ Grade: ____________________________
Teacher/case manager: ____________________________
☐ Yes ☐ No   Do you feel the school meets your child’s needs?
☐ Yes ☐ No   Do you have regular contact with their teachers?
☐ Yes ☐ No   Is your child receiving special education services?
☐ Yes ☐ No   Was your child ever retained a grade?
☐ Yes ☐ No   Does your child participate in extracurricular activities at school?
☐ Yes ☐ No   Does your child struggle academically at school?
☐ Yes ☐ No   Does your child have behavior problems at school?
☐ Yes ☐ No   Has your child ever been suspended or expelled from school?
☐ Yes ☐ No   Does your child miss school regularly?
How many days of school has your child missed this school year? ____________________________
How many days of school did your child miss the previous year? ____________________________
Highest educational level reached by parents:
Mother: ____________________________
Father: ____________________________

SUPPORTIVE FACTORS
List any previous mental health services your child has received:
Clinic Name: ____________________________ Therapist Name: ____________________________ Dates: ____________________________ Was it helpful? ☐ Yes ☐ No
1. ____________________________ ____________________________ ☐ Yes ☐ No
2. ____________________________ ____________________________ ☐ Yes ☐ No
3. ____________________________ ____________________________ ☐ Yes ☐ No
4. ____________________________ ____________________________ ☐ Yes ☐ No

☐ Yes ☐ No   Does your child have a probation officer?
☐ Yes ☐ No   Does your child have a County Social Worker?
☐ Yes ☐ No   Does your child have a Guardian ad Litem (GAL)?
☐ Yes ☐ No   Does your child have any other service providers?
Describe: ____________________________

☐ Yes ☐ No   Has your child ever been placed outside the home?
Where: ____________________________ Dates: ____________________________
1. ____________________________ ____________________________
2. ____________________________ ____________________________
3. ____________________________ ____________________________
4. ____________________________ ____________________________

Who are the people or services that you find supportive to you and your family (i.e. church, relatives)? Please be specific.

______________________________

Describe the role of religious and/or spiritual influences on your family:
Describe any extracurricular activities you have or recreational hobbies you participate in:

Please check any areas that you may be concerned about:

- Depression
- Anxiety
- Not Following Rules
- Bedwetting/Soiling
- Learning Difficulties
- Truancy
- Fighting
- Stealing
- Fire Setting
- Hot Temper
- Crying a lot
- Physical Abuse
- Nightmares
- Weight Loss
- Promiscuity
- Chemical Use
- Lack of Friends
- Panic Attacks
- Violent
- Destroys Things
- Sexual Abuse
- Running away from home
- Excessive Worrying
- Strange Behaviors
- Suicidal thoughts/plans
- Hyperactivity
- Avoid Others
- Self Injurious Behavior
- Vandalism
- Physical problems with no known medical cause

Please elaborate about anything you mentioned above that you are concerned about/any other stressors you are dealing with:

**YOUR CHILD’S STRENGTHS (Check all that apply)**

- Stays Active
- Independent
- Helpful
- Share with Others
- Good Looking
- Athletic
- Structures Time Well
- Liked by Adults
- Gets Along with Parents Others
- Employed
- Positive Outlook
- Easy Going
- Maintain Friends
- A Leader
- Liked by Others
- Responsible
- Tells you where they are
- Gets Along with Siblings
- Volunteers
- Involved with Positive Adults
- Attend school/Work Regularly
- Spiritual
- Intelligent
- Liked By Peers
- Has a hobby
- Structure Time Well
- Good Health
- Cope with problems well
- Humorous
- Caring
- Playful
- Artistic
- Responsible
- Positive view of the world
- Does Homework

**FAMILY STRENGTHS (Check all that apply)**

- Parents Employed
- Clear Rules at Home
- Sense of Humor
- Knows Child’s Friends
- Consistent Parenting
- Know How Child is Doing at School
- Go on Vacations Together
- Relatives Involved with Child
- Good Support Network
- Volunteer in Community
- Parents Get Along
- Know Parents of Child’s Friends
- Often Eat Supper Together
- Do Activities Together
- Involved at Child’s School
- Help Children with Problems
- Attend Church
- Caring
- Resilient
- Good Communication
- Able to Show Affection
- Strong Ethnic/Cultural Identity
- Children have Jobs in the Home

What would you like to see come out of services for your child?
Is there any other information that would be helpful to know in helping your child?


COMPLETED BY: ______________________________________________  DATE: ______________

Relationship to child: ____________________________________