Child Questionnaire

All information you provide will be kept confidential, according to the enclosed HSA Confidentiality Policy.

Please fill in all items as completely as you can. Use extra pages if necessary. If you do not have the information requested, please write "unknown". If an item does not apply to the child, write "NA". Please return the form to the Front Desk Receptionist or bring with you to your appointment.

Full name of person completing form: _____ Relationship to child: _____

Referral source: _____ Date: _____

Child's full name: _____ Gender: _____ Race: _____

Address: _____ Phone: ( ) -
Street City/State Zip

Cell Provider: _____

E-mail Address: _____ Preferred contact method? _____

Birthdate: _____ Age: _____ School Grade: _____ Is child adopted? No Yes: _____
Mo. /Day/ Year Years Mos. At Age

Siblings:

Name First Last	Gender	Age	School Grade or Occupation	Relationship to child	Mental Health / Substance Abuse
				O Sibling(s): O Full O Half O Step O Foster O Other	
				O Sibling(s): O Full O Half O Step O Foster O Other	
				O Sibling(s): O Full O Half O Step O Foster O Other	
				O Sibling(s): O Full O Half O Step O Foster O Other	
				O Sibling(s): O Full O Half O Step O Foster O Other	
				O Sibling(s): O Full O Half O Step O Foster O Other	
				O Sibling(s): O Full O Half O Step O Foster O Other	
				O Sibling(s): O Full O Half O Step O Foster O Other	

Parent(s)/Caregiver(s):

Name First Last	Gender	Age	Occupation	Relationship to child	Substance Use? Please describe:	Mental Health Difficulties?
				O Step O Biological O Foster O Other		
				O Step O Biological O Foster O Other		
				O Step O Biological O Foster O Other		
				O Step O Biological O Foster O Other		
				O Step O Biological O Foster O Other		
				O Step O Biological O Foster O Other		

Has the child ever been hospitalized for a mental health issue? (Include location, dates, length, and reason)

Has the child had previous mental health services? (If so, list agency, clinician, and periods of services)

Has the child seen a psychiatrist before? (If so, include location, clinician, diagnosis, and reason)

Has the child ever hurt themselves or attempted suicide? (Include details)

Child's Primary Care Physician: _____ Facility: _____

Preferred Pharmacy: _____ Location: _____

What medications, herbs, vitamins, essential oils, or other over-the-counter medications does the child take?
(Include name, dosage, prescriber, and what it treats)

List all medical diagnoses/struggles, including allergies:

Has the child ever had a head injury?

Has the child ever had a seizure?

Is the child pregnant?

Do the child's symptoms happen or worsen before their menstrual cycle?

Has the child ever been treated for chemical dependency/substance abuse?

Alcohol:	Last time used: _____	How often used: _____
Nicotine:	Last time used: _____	How often used: _____
Caffeine:	Last time used: _____	How often used: _____
Marijuana:	Last time used: _____	How often used: _____
Cocaine/Crack:	Last time used: _____	How often used: _____
Heroin:	Last time used: _____	How often used: _____
LSD:	Last time used: _____	How often used: _____
Meth:	Last time used: _____	How often used: _____
Fentanyl:	Last time used: _____	How often used: _____

Other: _____

Legal concerns:

Who does the child play with?

What does the child do for fun?

Does the child have a spiritual or religious preference?

What is the reason for the child's appointment today?

Is there a history of trauma? (If so, please explain):

Is there a history of abuse? (If so, please explain):

Were there any difficulties during pregnancy and delivery with this child?

- O None
- O C-Section
- O Forceps used
- O Medical problems during pregnancy
- O Premature
- O Other:

Were there any difficulties during the first year?

- O None
- O Required incubation
- O Hospitalized for medical problems:
- O Separation from parents for 1 - 4 weeks
- O Separation from parents for 5 - 8 weeks
- O Separation from parents for more than 8 weeks
- O Other: _____

Has any parent had major medical problems?

Was the child diagnosed with colic as an infant?

Has the child had any head injuries or high fevers?

Did/does the child have delays in:

○ Crawling ○ Walking ○ Talking ○ Toilet Training ○ Other: _____

Has the child received any of the following services:

○ Speech Therapy ○ Occupational Therapy ○ Physical Therapy ○ Other: _____

Current academic performance (include if on IEP or 504):

Has the child ever been on medication to reduce activity level?

Has the child ever been on medication to improve concentration?

Has the child had digestive disturbance?

○ Constipation ○ Diarrhea ○ Incontinence

Does the child have hearing loss?

Does the child have vision loss?

When was the child's last medical exam?

Rate the child's overall activity level:

○ High ○ Medium ○ Low

Rate the child's overall tolerance for frustration:

○ High ○ Medium ○ Low

At what age was it noticed this child was unusually active?

○ 0-2 years ○ 2-4 years ○ 4-6 years ○ 6+ years ○ Not Applicable

Has there been any change since then? (Explain the change, if any)

Can this child play alone for more than:

○ 15 minutes ○ 30 minutes ○ 1 hour ○ Longer than 1 hour

How well does this child play with others?

○ Very well ○ Well ○ Fair ○ Not well

Can the child pay attention when playing a game with you?

Does the child change toys frequently?

Can the child complete a game with you?

Can the child complete a TV program?

When watching TV, does the child understand the program?

Is the child restless or active when watching TV?

Is the child disruptive when eating at the table with family members?

Is the child overly messy?

Would you consider the child to be:

- ○ Restless ○ Destructive ○ Impulsive ○ Distractible

Does the child have any nervous mannerisms? (tics, twitches, eye blinking, chewing lips or fingers)

Does the child have friends similar in age?

Does the child have difficulty keeping friends?

Does the child seem fearless or heedless to danger (no worry about being hurt)?

Has the school complained about the child's behavior?

Does the school report the same problems as you see at home?

Has the child been evaluated by the school?

Has the child been evaluated by medical personnel?

What types of consequences have you tried?

- ○ Spanking ○ Grounding ○ Scolding ○ Removal of privileges ○ Sending to room
- ○ Natural ○ Reward ○ Other:

Have there been recent changes in the family?

Have there been any other changes at home?

Parent/Guardian's marital status:

○ Married ○ Separated ○ Divorced ○ Widowed ○ Never Married

Parent/Guardian's marital status:

○ Married ○ Separated ○ Divorced ○ Widowed ○ Never Married

Does the other parent have contact with this child?

If so, are there any problems with visitations? (If so, explain):

Does the child get along with siblings?

Are any siblings being treated for or have been evaluated for:

○ Hyperactivity ○ Attention problems ○ Behavior problems ○ Learning problems

Does this child require more reminders than their siblings?

Any other information you want the clinician to know?