MISSOURI CITY
FAMILY COUNSELING

CHILD/ADOLESCENT HISTORY QUESTIONNAIRE

Please answer the following questions carefully and completely.
Your answers will help us greatly in our understanding of your child.
The questionnaire will be reviewed with you, so it will be possible to discuss your answers if necessary.

CHILD/ADOLESCENT INFORMATION:

Child's Name:_____ Gender :_____

Age:_____ Date of Birth:_____ Grade:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Referred by:_____

Does the child live with both biological parents?_____

If not, who is the child's primary caregiver?_____

For how long?_____ Relationship to child:_____

*** Please provide documentation of custody or guardianship arrangements if applicable*

Emergency contact (Name/Phone): _____

PARENT/GUARDIAN INFORMATION:

Parent/Guardian (#1) Name:_____ DOB:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip Code:_____

Employment/Occupation:_____ Work #:_____

E-mail: _____

Parent/Guardian (#2) Name:_____ DOB:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip Code:_____

Employment/Occupation:_____ Work #:_____

E-mail: _____

PROBLEMS AND CONCERNS:

Please list, in order of urgency, the problem(s) for which you are seeking support for your child:

A. _____

B. _____

C. _____

D. _____

E. _____

FAMILY INFORMATION:

1. Who is this child currently living with? (check all that apply)

___Biological mother ___Stepmother

___Biological father ___Stepfather

___Maternal Grandmother ___Foster parents

___Paternal Grandmother ___Adoptive parents

___Maternal Grandfather ___Other (describe)_____

___Paternal Grandfather

2. List all children living in the child's home:

Name Age Relation to child

_____

_____

_____

_____

_____

3. Other brothers and sisters <u>not</u> living in the home:

Name Age Relation to child Occupation/Grade

_____

_____

_____

_____

4. Please list anyone in the child's extended family who has experienced difficulties with:

Problem	Relationship to child
Psychiatric problems	_____
Depression	_____
Anxiety	_____
Explosive temper	_____
Convulsions or seizures	_____
Mental retardation	_____
Learning disability	_____
Hyperactivity	_____
Attention problems	_____
Alcohol abuse	_____
Drug abuse	_____
Criminal charges	_____
Domestic violence	_____
Sexual abuse	_____

5. Please list the important changes that have occurred in your child's lifetime (for example: deaths, marital separations, divorces, remarriages, family moves, loss of important friendships, serious illnesses, financial problems, periods of parental conflict, etc).

_____

_____

_____

6. Please describe any history of trauma, including physical abuse, sexual abuse, physical and emotional neglect, verbal abuse, exposure to family violence, substance use by caregivers, imprisonment of caregivers, or long-term separation from caregivers.

_____

_____

_____

BIRTH HISTORY:

1. Was the pregnancy: ___Planned ___Unplanned

(check all that apply) ___With prenatal care ___Without prenatal care

2. Age of parents at time of child's birth: _____Mother _____Father

3. While mother was pregnant, did she have any of the following difficulties? (check all that apply)

___Measles
___Frequent nausea or vomiting
___Swelling or toxemia
___Flu, infections, high fever
___High blood pressure
___Hospitalizations
___Kidney disease
___Pneumonia
___Headaches
___Spotting or bleeding
___Depressed
___Very overweight
___Very underweight
___Heart trouble
___Diabetes
___Venereal disease
___Financial problems
___Marital problems
___Family problems
___Other social problems:
___Significant anxiety

4. Please specify if any of the following occurred during pregnancy:

□Chronic disease _____
□Accidents/injuries_____
□Surgeries _____
□Medications _____
□Alcohol intake _____
□Drug use _____
□Exposure to toxic chemicals or substances_____
□Stressful events for one or both parents_____

5. Information regarding childbirth:

How long did labor last:_____ Birth weight: _____
Was baby full term? _____ If not, how many weeks premature?_____
Describe the father's role in the delivery:_____
Length of hospital stay for mother: _____Length of stay for baby:_____
Were any of the following present during or soon after delivery? (check all that apply)

___Mother was put to sleep
___C-section performed
___Instruments used to deliver
___Baby was jaundiced (yellow)
___Baby aspirated meconium (breathed waste)
___Baby needed blood

___Rh factor present

___Breech birth or presentation

___Born with cord around neck

___Baby was blue

___Baby needed oxygen

___Baby had trouble sucking

___Baby had trouble keeping food down

___Baby was placed in an incubator. For how long?_____

___Other medical problems at birth (describe): _____

DEVELOPMENTAL HISTORY:

1. Did any of the following occur during infancy?

(check all that apply) Please Describe

_____Baby had problems sleeping_____

_____Baby was frequently fussy or colicky _____

_____Baby had unusual crying_____

_____Baby had trouble breathing_____

_____Baby had problems eating or gaining weight_____

_____Baby experienced convulsions, seizures, or "spells"_____

_____Baby had excessive diarrhea or dehydration _____

_____Mother was depressed, anxious, or unusually stressed _____

_____Mother was physically ill or injured _____

2. How do you feel your child developed in the following areas? (please check one)

Physical & motor development: ___Faster than average ___Average ___Slower than average

Talking & language development: ___Faster than average ___Average ___Slower than average

Relationships and social development: ___Faster than average ___Average ___Slower than average

3. Estimate the age at which the following occurred (please leave blank if you cannot remember):

Age:

_____smiled

_____held head up

_____sat without support

_____stood up

_____took first steps

_____walked alone

_____weaned from breastmilk

Age:

_____spoke first word

_____spoke in phrases

_____spoke in sentences

_____toilet trained—bladder

_____toilet trained—bowel

_____dressed self

MEDICAL HISTORY:

1. Has your child had any serious illnesses, injuries, or accidents?

Type	Age

2. Has your child ever been hospitalized?

Reason	Age

3. Please write the age (in years) when your child had any of the following medical problems:

Age:	Age:	Age:
_____Allergies	_____Head injuries	_____Pneumonia
_____Asthma	_____Heart trouble	_____Prolonged colic
_____Blood transfusion	_____High fever	_____Tonsillitis
_____Convulsions/ seizures	_____Infections (meningitis, encephalitis)	_____Frequent ear aches
_____Diabetes	_____Major fractures	_____Frequent colds/ sore throats
_____Fainting	_____Menstrual problems	_____Tics, twitching
_____Frequent stomach aches	Other:_____	

4. Please list your child's pediatrician, medical specialists, and the name of their group/facility:

5. My child's current medications are:

Medication	Dosage	Frequency

6. Please describe any problems your child had in the following areas:

Vision: _____

Hearing: _____

Speech: _____

7. Has your child experienced any changes or concerns related to eating habits? Yes ____ No ____ (describe):

_____

_____

8. Please describe your child's sleeping habits. (Please note any problems going to sleep, sleeping alone, night awakenings, length of sleep, nightmares, sleep walking, etc.)

_____

_____

9. Has your child ever received the following professional services outside of school?

Services	Ages	Name of Professionals
_____Psychological	_____	
_____Psychiatric	_____	
_____Neurological	_____	
_____Counseling/Therapy	_____	
_____Educational	_____	

ACADEMIC HISTORY:

1. Current grade:_____ School:_____

2. Did your child attend day care? _____How old was your child when s/he started?_____

3. Please list below the day care centers, preschools, and schools attended:

School	Location (City, State)	Ages/Grade

4. Has your child ever repeated a grade? Yes _____ No _____ If yes, what grade and what was the reason?

_____

5. Please write the grade in which your child began receiving any of the following services in school:

_____Head Start _____Early reading program (Title I) _____Speech Therapy

_____Physical Therapy _____Occupational Therapy _____School Counselor

_____Resource Room _____Content Mastery Center _____Special Education

6. Special Education Qualification: (circle all that apply)

□ MR □ LD □ OHI □ TBI □ VI □ SI □OI □ED

Please list any academic subjects that were addressed with these services:

_____

7. Please indicate your child's current school performance:

Subject	Failing	Below Average	Average	Above Average
Reading				
Writing/Spelling				
Mathematics				
Science				
Social Studies				
Other (specify):				

8. Please describe any changes in your child's academic performance, either recently or over the course of his/her school career:

_____

_____

9. School homework for this child: (check all that apply and describe further)

___ Is a source of unhappiness and trouble. _____

___ Is something s/he has to be forced to do. _____

___ Is something father helps with most. _____

___ Is something mother helps with most. _____

TEMPERAMENT:

1. What are the qualities you like best about your child's personality and temperament?

_____

_____

2. What are some troublesome qualities you notice about your child's personality and temperament?

_____

_____

DISCIPLINE:

1. This child is disciplined by (check all that apply):

___Mother ___Father ___Brother/sister ___Other:_____

2. Types of discipline most often used:_____

_____

3. Type of discipline that is most effective with this child: _____

_____

4. Describe how this child reacts to punishment:_____

_____

SOCIAL FUNCTIONING:

1. Compared to other children of his/her age, how well does your child:

	Worse	Same	Better
Get along with brothers/sisters			
Get along with other children			
Behave with his/her parents			
Play/work alone			
Behave in public (restaurants, etc.)			
Behave with babysitters			
Behave at daycare/school			

2. Please list any jobs or chores that your child has: (For example, baby-sitting, paper route, making bed, etc)

_____

_____

_____

3. Describe any concerns you may have about your child's interactions with peers:

_____

_____

4. How many close friends does your child have?

___ No close friends

___ 1-2 close friends

___ Several close friends

What activities do they enjoy doing together? _____

_____

5. Please list any organizations, clubs, teams, or groups that your child belongs to:

_____

_____

6. Please list your child's special interests, hobbies, or extracurricular activities:

_____

_____

7. Please list your child's special strengths, talents, abilities:

_____

_____

OTHER IMPORTANT INFORMATION:

_____

_____

_____

_____