

Minor (Child) Client Information Questionnaire

In order for your child's therapist to be able to fully evaluate his or her needs, please fill out this questionnaire to the best of your ability. The information you provide is for the therapist only; this form is completely confidential.

Today's Date: _____ Person completing this form: _____

IDENTIFYING INFORMATION

Child's Name: _____ Current Age: _____ Gender: _____

Racial/Ethnic self-identification: _____ Religious/Spiritual Identity or Affiliation _____

Parent/Legal Guardian Name(s): _____

MAIN PURPOSE OF CONSULTATION

Why are you seeking services for this child at this time? (Include precipitating events / current stressors / relevant history)

Has the child ever had this type of problem before? YES NO

If "Yes," what prior attempts have been made to correct or change the problem(s), and how effective were these measures? (*please include contact with other professionals, medications, types of treatment, etc.*)

What are your/your child's goals or desired outcomes for therapy?

MEDICAL HISTORY

Please explain any significant medical problems, symptoms, or illnesses your child has had:

Has the child ever had a head injury (e.g., concussion, skull fracture) YES NO

If "Yes," please describe:

Current Medications (*if you need more room, please write on the back of this page*):

<i>Name of Medication</i>	<i>Dosage</i>	<i>Purpose</i>	<i>Name of Prescribing Doctor</i>

Previous medical hospitalizations (Approximate dates, reasons, outcomes):

Previous psychiatric hospitalizations (Approximate dates, reasons, outcomes):

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
If yes, please list approximate dates and reasons:

Substance Use

Does the child smoke or use tobacco? NO UNKNOWN YES
If YES, how much per day?

Does the child consume caffeine? NO UNKNOWN YES
If YES, how much per day?

Does the child drink alcohol? NO UNKNOWN YES
If YES, how much per day/week/month?

Does the child abuse/misuse prescription drugs? NO UNKNOWN YES
If YES, what kinds and how often?

Does the child abuse/misuse OTC drugs? NO UNKNOWN YES
If YES, what kinds and how often?

Does the child use any illegal drugs? NO UNKNOWN YES
If YES, what kinds and how often?

Has the child ever been in trouble or in risky situations because of substance use? NO YES
If YES, please describe:

Do you have any concerns about the child's use of any substances? NO YES
If YES, please explain:

FAMILY:

With whom does the child live? *(list members of household by role/relationship to child)*

How would you describe the child's relationship with his/her mother?

How would you describe the child's relationship with his/her father?

Are the child's parents still married or separated or divorced?

If parents separated or divorced, how old was the child when this occurred, and how do you think this affected him/her?

Please describe the child's relationship with his/her grandparents:

Have there been any other primary care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life:

How many sisters does the child have? _____ Ages? _____

How many brothers does the child have? _____ Ages? _____

How would you describe your child's relationships with his/her siblings?

Family Mental Health History

Have any of this child's close blood relatives (e.g., parents, siblings, grandparents, aunts, uncles, cousins) had problems with any of the following? Please check all that apply, and indicate relationships.

	<u>Condition/Problem/History</u>	<u>Relatives' Relationships</u>
	Anxiety	
	Depression	
	Domestic Violence	
	Drug/Alcohol Problems	
	Hyperactivity	
	Learning Disabilities	
	Legal Trouble	
	"Nervous Breakdown"	
	Physical Abuse	
	Psychiatric Hospitalization	
	Sexual Abuse	
	Suicide Attempts	
	Suicide	

SOCIAL SUPPORT, SELF-CARE, & EDUCATION:

POOR

EXCELLENT

Child’s current level of satisfaction with friends and social support: 1 2 3 4 5 6 7

How would you describe your child’s relationships with his/her peers?

Please briefly describe any history of abuse, neglect and/or trauma:

Please briefly describe the child’s self-care and coping skills:

What are the child’s diet, weight, and exercise/activity patterns?

Please briefly describe the child’s school performance and experience:

What are the child’s hobbies, talents, and strengths?

Current and Past Problems

Here is a list of problems that people sometimes have. PLEASE CHECK ALL THAT APPLY TO THIS CHILD, and indicate whether these are occurring now, in the past, or both.

DIFFICULTY WITH	NOW	PAST	DIFFICULTY WITH	NOW	PAST	DIFFICULTY WITH	NOW	PAST
Abuse: Physical			Fidgets Frequently			School		
Abuse: Sexual			Fighting			Sensory Issues		
Aggression			Fine-Motor Skills			Seizures		
Alcohol/Drugs			Friend(s)			Separation Anxiety		
Allergies			Getting to Sleep			Sexually Acting Out		

Anger or Temper			Gross-Motor Skills			Shortness of Breath		
Anxiety			Head Injury			Siblings		
Asthma			Headaches (frequent)			Skin disorders		
Bed-wetting			Heart Problems			Sleeping Alone/ In Own Bed		
Bruises Easily			Hurting Self			Sleeping Too Little		
Caffeine Use			Hyperactivity			Sleeping Too Much		
Careless Mistakes (frequent)			Impulsivity			Sleepwalking		
Chest Pain			Irritability			Snoring (heavy)		
Chills or Hot Flashes			Jaundice			Stealing		
Communicating			Legal Issues			Stomach Aches (frequent)		
Completing Tasks			Lying (frequent)			Sweating (Excessive)		
Concentration			Memory Loss			Tantrums		
Constipation (frequent)			Mood Changes			Thoughts of Hurting Someone		
Cries Easily			Muscle Tension			Thoughts of Suicide		
Depression			Nausea (Frequent)			Trusting Others		
Diarrhea (frequent)			Night Terrors			Truancy		
Dizziness			Nightmares			Vandalism		
Domestic Violence			Nosebleeds (frequent)			Vomiting (frequent)		
Ear Infections (frequent)			Panic			Waiting His/Her Turn		
Easily Distracted			Parents Divorced			Waking Too Early		
Eating Problems			Paying Attention			Weight Gain (Severe)		
Fainting			Premature Birth			Weight Loss (Severe)		
Fear of Strangers			Respiratory Illness (frequent)			Worry (Excessive)		
Fears / Phobias			Rule-breaking					

Any additional information you would like to include that you think would be helpful for the therapist to know: