



SHEEP GATE CHRISTIAN COUNSELING

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CHILD & ADOLESCENT LIFE HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to obtain a comprehensive understanding of your child's life experience and background. Completing these questions as fully and as accurately as you can, will benefit your child through the development of a treatment program suited to his/her specific needs. Please return this questionnaire at your child's first scheduled appointment.

Intake Questions

PLEASE COMPLETELY FILL OUT THE FOLLOWING PAGES WITH YOUR CHILD

Child's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone number(s) you want to be contacted at:

Home Phone: _____ Work Phone (if applicable): _____ Cell Phone: _____

Social Security #: _____ Gender: _____ Age: _____ DOB: _____

Place of Birth: _____ Who referred you? _____

Where do you reside? house hotel room apartment other: _____

Who should we contact in an emergency? Name: _____

Relationship: _____ Address: _____

_____ Telephone: _____

EDUCATION: Circle your child's current grade level:

K 1 2 3 4 5 6 7 8 9 10 11 12

Is your child experiencing any academic difficulties in school? Yes No

If yes, please describe the nature of the difficulties: _____

Has these difficulties ever stopped your child from progressing to the next grade level? Yes No

If yes, please explain: _____

How often has your child changed schools? _____

Has your child ever required special education services in school? Yes No

If yes, please explain: _____

Has your child's school ever completed or recommended that an evaluation be done on your child for academic or behavior problems? Yes No. If yes, please explain what evaluation(s) was completed or recommended:

Describe your child's behavior problems in school: _____

Has your child ever been suspended or expelled? Yes No
If yes, please explain: _____

What kind of extracurricular activities are your child involved in? _____

Significant relationship status of child's parent(s) (check all that apply):

Mother		Father	
<input type="checkbox"/> single (never married)	<input type="checkbox"/> divorced	<input type="checkbox"/> single (never married)	<input type="checkbox"/> divorced
<input type="checkbox"/> engaged	<input type="checkbox"/> remarried	<input type="checkbox"/> engaged	<input type="checkbox"/> remarried
<input type="checkbox"/> married	<input type="checkbox"/> committed relationship	<input type="checkbox"/> married	<input type="checkbox"/> committed relationship
<input type="checkbox"/> separated	<input type="checkbox"/> widowed	<input type="checkbox"/> separated	<input type="checkbox"/> widowed

If engaged, married, separated, divorced or widowed, for how long? _____

Number of previous marriages for you: _____ For your spouse/partner: _____

If married, spouse's name: _____ Age: _____ Occupation: _____

Is your spouse/partner supportive of seeking counseling? Yes No Unsure Spouse/Partner doesn't know

Please provide a brief description of your spouse/partner (e.g., angry and controlling; outgoing and supportive): _____

What is your spouse or partner's religious affiliation? _____

If you are separated or divorced, what are the custody arrangements for your child? (i.e. legal, joint, physical, visitation, etc.)

If parents do not have custody of the child, is there a legal guardian? Yes No
If yes, who is the legal guardian? _____

Are there any pending custody or visitation cases currently? Yes No
If yes, please explain: _____

Does your child have step-parents? Yes No
If yes, please explain: _____

If single, are you living in a committed relationship? Yes No
If yes, how long have you been together? _____

Is your partner involved in your child's life? Yes No
If yes, please describe his/her involvement: _____

CHILDREN: None (Please check box if applicable)

Please list all other children (including step, adopted, foster) for you or your spouse/partner below:

Name	Gender	Age/Yr. of Death	Relationship w/you	Living with whom?

Who else lives with you? _____

SPIRITUAL/RELIGIOUS HISTORY

Check the appropriate box if you want Christian Counseling Yes No

Do you and your child regularly attend a church, synagogue, or other religious institution? Yes No
If yes, which one? _____

Describe your and your spouse's/partner's participation: _____

Describe your child's participation: _____

Have you and your spouse/partner recently changed religious affiliation? Yes No

Describe the religious atmosphere your child is being raised in: _____

How does your child feel about his/her religion? _____

What is the role of religion/spirituality in you and your spouse's/ partner's life: _____

What is the role of religion/spirituality in your child's life? _____

Describe any spiritual experiences that have shaped your child's life: _____

CHIEF COMPLAINT: Please consult with your child on this section. Check all that applies to your child whether past or present:

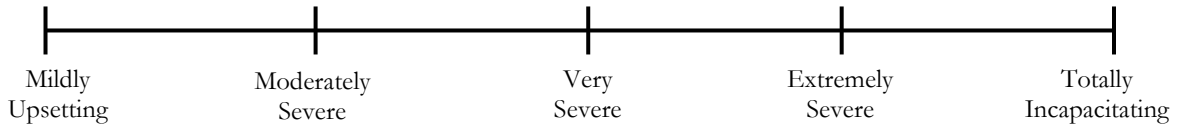
LIST 1	LIST 2	LIST 3
<input type="checkbox"/> Stress	<input type="checkbox"/> Marital Problems	<input type="checkbox"/> Compulsive Behaviors
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Other Relational Problems	<input type="checkbox"/> Seeing Things Others Don't
<input type="checkbox"/> Panic	<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Hearing Voices
<input type="checkbox"/> Depression	<input type="checkbox"/> Emotional Abuse	<input type="checkbox"/> Racing Thoughts
<input type="checkbox"/> Apathy	<input type="checkbox"/> Verbal Abuse	<input type="checkbox"/> Eating Problems
<input type="checkbox"/> Fatigue/Lack of Energy	<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Drug Use
<input type="checkbox"/> Loss of Appetite/Overeating	<input type="checkbox"/> Sexual Problems	<input type="checkbox"/> Alcohol Use
<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Gender Identity Issues	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Poor Concentration	<input type="checkbox"/> Anger	<input type="checkbox"/> Abortion
<input type="checkbox"/> Feeling Worthless	<input type="checkbox"/> Aggressive Behavior	<input type="checkbox"/> Legal Matters
<input type="checkbox"/> Recent Death	<input type="checkbox"/> Bad Dreams	<input type="checkbox"/> Work Stress
<input type="checkbox"/> Grief	<input type="checkbox"/> Unwanted Memories	<input type="checkbox"/> Career Choices
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Loss of Control	<input type="checkbox"/> Indecisiveness
<input type="checkbox"/> Loneliness	<input type="checkbox"/> Impulsive Behavior	<input type="checkbox"/> Parenting Problems
<input type="checkbox"/> Fears	<input type="checkbox"/> Controlling	<input type="checkbox"/> Financial Problems
<input type="checkbox"/> Shyness	<input type="checkbox"/> Controlled by Others	<input type="checkbox"/> Spiritual Problems
<input type="checkbox"/> Low Self-Esteem	<input type="checkbox"/> Obsessive Thoughts	<input type="checkbox"/> Other: _____

NATURE OF PRESENTING PROBLEM/CHIEF COMPLAINT

- A. State in your own words the nature of the main problem(s) your child is experiencing currently: _____

- B. In your child's own words state the nature of the main problem(s) he/she is experiencing currently: _____

C. On the scale below please use an "X" to indicate the severity of your child's problem(s):



COUNSELING HISTORY

If your child has had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs below:

Therapist's Name or Program	Major Issue/Diagnosis	Dates

- A. When was your child first diagnosed with a mental illness? _____
- B. Was your child ever hospitalized because of mental illness? Yes No
 If yes, When? _____ Where? _____

C. How many times have your child been hospitalized? _____

D. Have your child ever attempted suicide or homicide? Yes No
If yes, how many times? _____

E. Is he or she currently feeling suicidal or homicidal? Yes No
If yes, does your child have a plan? Yes No
If yes, please describe: _____

F. Has your child ever engaged in self-injurious behaviors (cutting, head-banging, etc.)? Yes No
If yes, please explain: _____

MEDICATION COMPLIANCE

A. If your child is presently taking psychotropic medication(s) please list each one below:

Name	Dosage/Schedule	Reason For Taking

B. Does your child know his/her medication schedule? Yes No

C. Do you think the medication is helping? Yes No

D. Does the child think the medication is helping? Yes No

E. Does your child experience any side-effects? Yes No
If yes, describe symptoms: _____

MEDICAL HISTORY

A. Please list any major conditions, illnesses, accidents, surgeries, treatments or hospitalizations your child has had and when they occurred? _____

B. Is your child currently receiving any medical treatment? Yes No
If yes, please describe: _____

C. Who is the child's Primary Care Physician? _____

Please list any non-psychotropic prescription and over-the-counter medications your child is currently taking and the reasons for taking them. (List even if your child seldom uses, or take only as needed.)

Name of Medication(s)	Dosage/Schedule	Reason for Taking

E. Is your child taking these medications according to the doctor's recommendations? Yes No

If no, please explain: _____

F. Date and outcome of your child's last physical exam: _____

G. What is your child's height? _____ What is your child's weight? _____

H. Does your child menstruate? Yes No Does she have regular periods? Yes No

I. Does your child's periods affect her moods? _____

J. Describe any regular exercise regimen your child engages in: _____

DEVELOPMENTAL HISTORY (check all that apply for your child/adolescent)

Problems During	Birth:	Childhood Health:	
Mother's Pregnancy:	<input type="checkbox"/> normal delivery	<input type="checkbox"/> chickenpox (age _____)	<input type="checkbox"/> lead poisoning (age _____)
	<input type="checkbox"/> difficult delivery	<input type="checkbox"/> German measles (age _____)	<input type="checkbox"/> mumps (age _____)
<input type="checkbox"/> none	<input type="checkbox"/> cesarean delivery	<input type="checkbox"/> red measles (age _____)	<input type="checkbox"/> diphtheria (age _____)
<input type="checkbox"/> high blood pressure	<input type="checkbox"/> complications _____	<input type="checkbox"/> rheumatic fever (age _____)	<input type="checkbox"/> poliomyelitis (age _____)
<input type="checkbox"/> kidney infection	_____	<input type="checkbox"/> whooping cough (age _____)	<input type="checkbox"/> pneumonia (age _____)
<input type="checkbox"/> German measles	birth weight ____lbs ____oz.	<input type="checkbox"/> scarlet fever (age _____)	<input type="checkbox"/> tuberculosis (age _____)
<input type="checkbox"/> emotional stress		<input type="checkbox"/> autism	<input type="checkbox"/> mental retardation
<input type="checkbox"/> bleeding	Infancy:	<input type="checkbox"/> ear infections	<input type="checkbox"/> asthma
<input type="checkbox"/> alcohol use	<input type="checkbox"/> feeding problems	<input type="checkbox"/> allergies to _____	
<input type="checkbox"/> drug use	<input type="checkbox"/> sleep problems	<input type="checkbox"/> significant injuries _____	
<input type="checkbox"/> cigarette use	<input type="checkbox"/> toilet training problems	<input type="checkbox"/> chronic, serious health problems _____	
<input type="checkbox"/> other _____			

Delayed Developmental Milestones (check only those milestones that did not occur at expected age):

- sitting
- rolling over
- standing
- walking
- feeding self
- speaking words
- speaking sentences
- controlling bladder
- other _____
- controlling bowels
- sleeping alone
- dressing self
- engaging peers
- tolerating separation
- playing cooperatively
- riding tricycle
- riding bicycle

Emotional/Behavior Problems (check all that apply):

- drug use
- alcohol abuse
- chronic lying
- stealing
- violent temper
- fire-setting
- hyperactive
- animal cruelty
- assaults others
- disobedient
- repeats words of others
- not trustworthy
- hostile/angry mood
- indecisive
- immature
- bizarre behavior
- self-injurious threats
- frequently tearful
- frequently daydreams
- lack of attachment
- distrustful
- extreme worrier
- self-injurious acts
- impulsive
- easily distracted
- poor concentration
- often sad
- breaks things
- other _____

Social Interaction (check all that apply):

- normal social interaction
- isolates self
- very shy
- alienates self
- inappropriate sex play
- dominates others
- associates with acting-out peers
- other _____

Intellectual / Academic Functioning (check all that apply):

- normal intelligence
 - high intelligence
 - learning problems
 - authority conflicts
 - attention problems
 - underachieving
 - mild retardation
 - moderate retardation
 - severe retardation
- Current or highest education level _____

Describe any other developmental problems or issues: _____

SUBSTANCE ABUSE HISTORY

To your knowledge:

1. Does your child smoke tobacco? Yes No.
 - a. How many: ___ packs per day ___ cigars per day Other products: _____
 - b. Describe: _____
2. How often does your child consume alcohol? _____
 - a. What does your child usually drink? Beer Wine Liquor N/A
 - b. Have your child ever had an alcohol related injury? Yes No. If yes, please describe: _____

3. Have your child ever used illegal drugs? Never In the past Currently
 If yes, list the drug(s) your child used: _____
4. Does your child ever misuse prescription or over-the-counter medication(s)? Yes No
 If yes, which one(s) does your child misuse? _____
5. How much of the following does your child drink each day? ___ caffeinated soda ___ tea ___ coffee
6. Have your child ever been in trouble with the law? Yes No
 If yes, explain: _____

FAMILY HISTORY: Please list your child’s father, mother, sister(s), brother(s), step family relations, or other family members who have had a significant effect on your child’s life (either positive or negative).

Name	Gender	Age/Yr. of Death	Relationship w/you	Describe your child’s relationship with each family member listed (e.g., loving & supportive, argumentative & controlling, etc.)

*Please use back of form if you run out of space.

2. Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions? Yes No
 If yes, please describe: _____
3. Have any of your family members or friends ever attempted or committed suicide? Yes No
 If yes, please describe: _____

FRIENDS

1. Does your child have friendships? Yes No
2. Have your child describe his/her closest friend(s)? _____

3. Does your child make friends easily? Yes No. Explain: _____
4. Does your child keep friendships? Yes No. Explain: _____
5. Was your child ever bullied or severely teased? Yes No. Explain: _____

TREATMENT EXPECTATION & GOALS

1. In a few words, what do you think therapy is all about? _____

2. What do you expect to accomplish from therapy, and how long do you expect therapy to last? _____

3. Please add any information not brought up by this questionnaire that may aid your therapist in understanding and helping you. (List any additional problems or difficulty here): _____

Client's Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____