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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**	
☐ single (never married)	☐ divorced	☐ single (never married)	☐ divorced
☐ engaged	☐ remarried	☐ engaged	☐ remarried
☐ married	☐ committed relationship	☐ married	☐ committed relationship
☐ separated	☐ widowed	☐ separated	☐ 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:

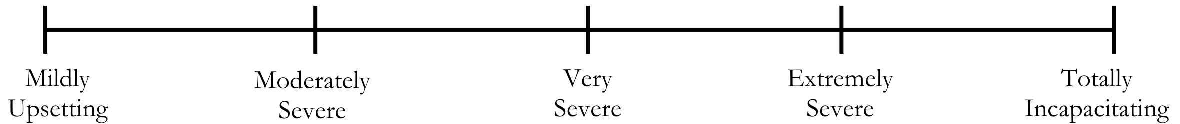
LIST 1	LIST 2	LIST 3
☐ Stress	☐ Marital Problems	☐ Compulsive Behaviors
☐ Anxiety	☐ Other Relational Problems	☐ Seeing Things Others Don't
☐ Panic	☐ Physical Abuse	☐ Hearing Voices
☐ Depression	☐ Emotional Abuse	☐ Racing Thoughts
☐ Apathy	☐ Verbal Abuse	☐ Eating Problems
☐ Fatigue/Lack of Energy	☐ Sexual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



Mildly Upsetting | Moderately Severe | Very Severe | Extremely Severe | Totally Incapacitating

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 Mother's Pregnancy:

[ ] none
[ ] high blood pressure
[ ] kidney infection
[ ] German measles
[ ] emotional stress
[ ] bleeding
[ ] alcohol use
[ ] drug use
[ ] cigarette use
[ ] other

Birth:

[ ] normal delivery
[ ] difficult delivery
[ ] cesarean delivery
[ ] complications ______ ______________
birth weight _____lbs ____oz.

Infancy:

[ ] feeding problems
[ ] sleep problems
[ ] toilet training problems

Childhood Health:

[ ] chickenpox (age ___________)
[ ] German measles (age _______)
[ ] red measles (age ___________)
[ ] rheumatic fever (age _______)
[ ] whooping cough (age _______)
[ ] scarlet fever (age ___________)
[ ] autism
[ ] ear infections
[ ] lead poising (age __________)
[ ] mumps (age ______________)
[ ] diphtheria (age ____________)
[ ] poliomyelitis (age _________)
[ ] pneumonia (age ___________)
[ ] tuberculosis (age __________)
[ ] mental retardation
[ ] asthma
[ ] allergies to ______________________________
[ ] significant injuries ______________________________
[ ] chronic, serious health problems ______________________________
____

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: ____________