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CHILD/ADOLESCENT PSYCHOSOCIAL HISTORY QUESTIONNAIRE

Identifying Information:

Client Name: _____ Date: _____ Client # _____

[] Male [] Female Date of Birth: _____

The information in this form is very important to you counselor, who will be reviewing it with you. It is also very important to the success of your treatment that your counselor understands as much about you as possible. If English is not your primary language, or if you have any vision, reading or writing problems, which might make filling out this form more difficult, please tell a staff member, who will arrange for someone to help you. Please answer the questions as honestly as you can, and feel free to explain or add any other information. If a question does not apply to you or your situation, please write N/A. This information, like all other information you give us, is confidential.

Presenting Problems:

1. Do you believe you child has a problem, i.e. substance abuse, depression, anxiety, etc. If yes please explain:

2. Do you think this is a very important problem? If yes please explain: _____

3. How long has this been a problem? _____

4. Is this a recurrent problem? [] Yes [] No

5. Has this affected you and your family? If so please explain how. _____

6. Does your child believe he/she has a problem? [] Yes [] No

7. Does anyone in your child's immediate or extended family have a similar problem? Please explain. _____

Family/Cultural History:

1. What is your child's ethnicity? _____

2. Do you, your child, or your family identify with a particular cultural or ethnic group? Please explain. _____

3. Has this played an important role in any current problems with your child? Please explain _____

4. In whose custody has your child spent most of his/her childhood? _____

5. In what city or area has your child been raised? _____

6. What is the Father's name, age, and job? If deceased, how and when? _____

7. What is the Mother's name, age, and job? If deceased, how and when? _____

8. If applicable, what is the Step-Father's name, age, and job? If deceased, how and when? _____

9. If applicable, what is the Step-Mother's name, age, and job? If deceased, how and when? _____

10. Is your child adopted? Yes No
11. If so, does he/she know about his/her birth parents?
12. With whom does your child live? _____

13. How is he/she disciplined? _____

14. By whom is he/she disciplined? _____

15. If any, what are the names, ages, and genders of any siblings including step and half siblings? Do they live in the same place as him/her? _____

16. Please write any significant family history (include marriages, separations, substance/pyshical abuse, violence, death, disruptions, suicide/homicide). _____

17. How is your family supported?

Parent/Guardian Employment

Public Assistance

Other, please explain _____

18. Are there any Family legal issues? (sexual abuse, custody, foster care, etc.) _____

19. Has your child had legal circumstances (i.e. criminal, wardship, custody, foster care)? Please explain _____

20. Who in your family is your child closest to? Please explain. _____

21. Have any deaths or losses affected your child? Please explain. _____

Developmental History:

1. Pregnancy and birth information (length of pregnancy, birth length and weight, etc.) _____

2. Milestones (walk, talk, toilet trained, etc): _____

3. Pre-natal exposure to Alcohol, Tobacco and Other Drugs (ATODs)?

Yes No If yes, please describe: _____

4. Please list immunizations and date received: _____

5. Major illness (type/age of onset): _____

6. Allergies (type/age of onset): _____

7. Current medications, start date of meds, and name of prescribing doctor: _____

8. Has he/she ever had any kind of head injury? If so, when and how? _____

9. Has he/she ever lost consciousness as the result of an injury? If so, when and how? _____

10. Has he/she ever had any of the following? If so, please indicate child's age when occurred.

- frequent nightmares; age _____
- sleep walking; age _____
- thumb sucking; age _____
- stuttering; age _____
- nail biting; age _____
- excessive fear; age _____
- bed wetting; age _____
- soiling; age _____
- difficulty with language/speech; age _____
- difficulty with hearing; age _____
- difficulty with vision; age _____
- trouble with police; age _____
- trouble with authorities; age _____
- temper problems; age _____
- sexual activity; age _____
- pregnancy (self or girlfriend); age _____

- cigarette use; age _____
- alcohol use; age _____
- gambling; age _____
- criminal acts/non-violent; age _____
- criminal acts/violent; age _____
- truancy from school; age _____
- running away from home; age _____
- gang membership or participation; age _____
- involvement with weapons; age _____
- suicide attempts; age _____
- eating disorder; age _____
- mood difficulties; age _____
- mental illness; age _____
- fire starting; age _____
- treatment/mental health; age _____
- treatment/substance abuse; age _____
- hurt animals; age _____

11. Has he/she had any learning difficulties? If so, please explain. _____

12. How many schools has he/she attended? _____

13. Reasons for change of school? _____

14. Does your family belong to a spiritual organization? If so, which? _____

15. Does your child attend/participate? Yes No

16. Does he/she like participating? Please explain. _____

17. Will this affect treatment? If so, how? _____

18. Is he/she sexually active? Yes No Unsure

19. Has he/she ever been sexually abused? If so, please explain, including who abused him/her. _____

20. Does he/she use birth control? If yes, what type? _____

21. Does he/she practice safe sex techniques, if applicable? _____

22. Please indicate if your child has ever had any of the following?

- depression
- fears
- paranoid or suspicious thoughts
- seeing or hearing things
- low self-esteem
- nervousness
- hurting self
- anxiety
- suicidal thoughts or attempts
- panic attacks
- sleep problems
- guilt
- fighting
- mood swings
- memory problems
- irrational beliefs
- appetite disturbances
- frequent headaches
- frequent stomach aches
- frequent gastric upset
- feeling helpless
- feeling hopeless
- feeling inadequate
- setting fires
- hostile feelings or actions
- hurting animals
- strange, unexplained thoughts, sensations, or feelings
- poor concentration

23. Does he/she watch TV or play videos? If so, how many hours per day are spent at this activity? _____

24. Which types of shows or movies does he/she prefer? _____

25. How much leisure time do you spend with your child? _____

26. Are you satisfied with your child's use of leisure (non-school) time? Please explain. _____

27. Does he/she eat a well balanced diet? What types of food do they eat daily? _____

28. Do you think your child has an eating problem? If so, please explain. _____

29. What types of vitamins/food supplements does he/she take and how often are they taken? _____

30. Does he/she avoid any of the major food groups? If so, which? _____

31. Would you like a referral to a dietitian for your child? _____

32. What do you hope your child will receive from treatment? _____

33. What will happen if your child's problems are not resolved through this treatment? _____

34. Please list any past treatment your child has received, including the dates, purpose, and person providing treatment. _____

35. Is there anything else you would like to tell us in order to help us understand your child and his/her situation? _____

Client/Parent or Guardian Signature

Date

Therapist Signature

Date