MINOR CHILD INFORMATION QUESTIONNAIRE

Identification Information

Child's Name: _____ Age: _____ DOB: _____

Guardian's Name(s): _____ Phone:

_____

_____ Phone: _____

Child's Primary Address: _____ City: _____ State: _____

Zip: _____ Secondary Address: _____

City: _____ State: _____ Zip: _____

Guardian(s) Email: _____

_____

Is it O.K. to contact you at this number?

Yes No

Emergency Contact Other Than Guardians:

Name: _____Phone Number: _____

With whom does the child presently reside? _____ Can I add you to the maillist? Y/N

FAMILY INFORMATION AND PERSONAL BEHAVIORS

Father	Name: _____ Age: _____	
DOB: _____	Occupation: _____	
❑ Yes	❑ No	Has the child's father been married previously?
Mother	Name: _____ Age: _____	
DOB: _____	Occupation: _____	
❑ Yes	❑ No	Has the child's mother been married previously?
❑ Yes	❑ No	Were there problems during the pregnancy of this child? If yes, please explain:
		During pregnancy, did the child's mother:
❑ Yes	❑ No	Smoke during pregnancy?
❑ Yes	❑ No	Use alcohol?
❑ Yes	❑ No	Use street drugs (please list)
		_____
		_____
		_____

Please circle the disorders that any of child's blood relatives have had: * Alcoholism * Drug Addiction * Anemia * * Asthma * Cancer * Diabetes * Epilepsy * Heart Disease * High Blood Pressure * Low Blood Pressure * Stroke * * Hepatitis * Kidney Disease * Venereal Disease * Psychiatric Treatment * Depression * Suicide Attempts * Manic Depression * Anxiety * Fears * Phobias * ADHD/ADD * Obsession Compulsion w/ specific activities *

❑ Yes	❑ No	Does the child have siblings?

Name(s): Age(s):

_____ _____

_____ _____

_____ _____

_____ _____

❑ Good	❑ Fair	❑ Poor	What kind of relationship does the mother have with the child(ren)?
❑ Good	❑ Fair	❑ Poor	What kind of relationship does the father have with the child(ren)?
❑ Good	❑ Fair	❑ Poor	What kind of relationships do the children have with each other?
❑ Good	❑ Fair	❑ Poor	How does your child respond to physical affection?

How do you show your child that you love them?

_____

_____

What are the main methods of discipline used with your child and how effective have they been?

_____

_____

Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so please describe:

_____

_____

❑ Nail Biting ❑ Bedwetting ❑ Temper tantrums ❑ Running away ❑ Fears ❑ Nightmares ❑ Thumbsucking ❑ Other	Does the child exhibit any negative personal habits? Explain "other":

❑ Yes	❑ No	Does your child get into trouble or exhibit behavioral issues? If yes, please explain:

DOES YOUR CHILD HAVE ANY PETS? Y / N NUMBER OF PETS?

DOES YOUR CHILD HAVE ANY HOBBIES OR SPECIAL INTERESTS? Y / N PLEASE LIST BELOW:

SCHOOL EXPERIENCES

			What school and grade is the child currently enrolled in?
❑ Above Average ❑ Average ❑ Below Average			What kind of grades do they receive in school?
❑ Yes	❑ No		Has your child ever repeated a grade? If so which one(s): _____
❑ Yes	❑ No		Has your child ever received special education services?
❑ Yes	❑ No		Are they involved in any extra-curricular activities (band, sports, etc)?
❑ Yes	❑ No		Do they have any learning problems or complications?
❑ Yes	❑ No		Does your child have good friends that are healthy for them?
Good	Fair	Poor	Do they get along with their classmates?
Good	Fair	Poor	How well do they relate with their teachers?

Has your child experienced any of the following problems at School? (please circle all that apply)

* gang influence * incomplete homework * behavior problems * fighting* Bullying *

* detention * suspension * poor attendance * exposure to drugs/alcohol *

DEVELOPMENTAL HISTORY

❑ Good	❑ Fair	❑ Poor	How was/is the child's physical health from 0 - 12 years?
Explain anything unusual:			
❑ Good	❑ Fair	❑ Poor	How was/is the child's physical development from 0 - 12 years?
Explain anything unusual:			
❑ Good	❑ Fair	❑ Poor	How was/is the child's emotional development from 0 - 12 years?

Explain anything unusual:

Circle any of the following that **DID NOT** occur in a typical developmental time period:

Smiled * Sat without support * Walked alone * Spoke first word * Used two or three word sentences * Completely weaned * Started toilet learning * Completed toilet training * Tied shoes * Completely dressed him/herself *

Medical History

Doctor:_____	<<<<< Who is your child's pediatrician and Number:
	Phone: _____
Last Doctor Visit:_____	Address: _____
Yes / No	Is child currently taking any medications?
Please List Medications and dosages.	_____Dose: _____
	_____Dose: _____
	_____Dose: _____
	_____Dose: _____

Has your child experienced any of the following problems? (please circle all that apply)

* A serious accident * Hospitalization * Surgery * Asthma * Head injury * High fever

* Convulsions/Seizures * Eye problems * Meningitis * Hearing problems * Allergies *

* Loss of consciousness * Other * Explain "other":

_____

_____

Good 10 Poor 1 10 9 8 7 6 5 4 3 2 1	How would you rate the child's current overall health? (please circle)

PRESENT PSYCHOLOGICAL STATUS

Please describe the reason for seeking help for your child.		_____ _____ _____ _____
❑ Yes	❑ No	Has the child ever seen a counselor or mental health worker before? Why were you seeking help for them?: _____ _____
❑ Yes	❑ No	Was the counseling beneficial? Who was the counselor?: _____
❑ Yes	❑ No	Has the child ever been hospitalized for any emotional or psychological difficulties? What was the concern?: _____ _____
❑ Yes	❑ No	Is there anything currently bothering the child, causing them to worry or be stressed? _____ _____
❑ Yes	❑ No	Is the child having disturbances or difficulty with sleep?
❑ Yes	❑ No	Has the child experienced any changes in appetite or weight recently?
❑ Yes	❑ No	Has your child ever experienced any serious personal, emotional losses recently? Please explain:
❑ Short ❑ Medium ❑ Long		How would you rate your child's temper (fuse)?
❑ Yes	❑ No	Has your child ever made statements of wanting to hurt themselves or someone else? Explain: _____ _____ _____