

CHILD/ADOLESCENT LIFE HISTORY Questionnaire

The purpose of this questionnaire is to obtain a comprehensive understanding of your child—his/her life experience and background. In answering the following questions as accurately and completely as you can, you will facilitate in the development of a treatment plan that is best suited to your child's individual needs. If you would rather not answer a question, simply leave it blank or write, "do not want to answer." Use N/A where **not applicable**.

CHILD'S NAME: _____ **DATE:** _____

GENDER: (M) _____ (F) _____ **AGE:** _____ **DATE of BIRTH:** _____

ADDRESS: _____ **CITY, STATE, ZIP:** _____

Name of person completing form (please print): _____

Relationship to child: _____

Emergency contact information (of person completing form):

Phone (home) _____ (work) _____ (cell) _____

Address (street, city, state, zipcode) _____

Other emergency contacts:

Name (2): _____ **Relationship:** _____

Phone (home) _____ (work) _____ (cell) _____

Address (street, city, state, zipcode) _____

Name (3): _____ **Relationship:** _____

Phone (home) _____ (work) _____ (cell) _____

Address (street, city, state, zipcode) _____

Presenting Problems: (check or circle all that apply)

Sad, very unhappy	Moody	Angry, defiant
Cries frequently	Acts without thinking	Stealing
Irritable	Stubborn	Lying
Temper tantrums	Disobedient	Sexual acting out
Withdrawn, loner	Infantile	School performance
Daydreaming	Mean to others, bullies	Truancy
Fearful	Destructive	Bed wetting
Worries	Trouble with the law	Soiled pants
Clumsy	Running away	Eating problems
Overactive	Self-mutilating	Overweight
Slow	Head banging	Stomachaches
Short attention span	Rocking	Sleeping problems
Distractible	Shy	Nightmares
Lacks initiative	Avoids adults	Often ill
Lazy	Strange, unusual thoughts	Drug use
Undependable	Strange, unusual behaviors	Alcohol use
Peer conflict	Tics or twitches	Fire setting
Phobic	Eye blinking, jerking	Suicide talk

Are there any other problems not listed above? _____

How long have these problems occurred? (number of weeks, months, years)

Problems perceived to be: ___ very serious ___ serious ___ somewhat serious ___ not serious

What are your expectations of your child? _____

What changes would you like to see in your child? _____

Current Family Situation:

MOTHER—Relationship to child ___ natural parent ___ relative ___ step-parent ___ adoptive parent

Occupation _____ Education _____

Birthplace _____ Age _____

FATHER—Relationship to child ___ natural parent ___ relative ___ step-parent ___ adoptive parent

Occupation _____ Education _____

Birthplace _____ Age _____

Marital History of Parents:

Natural Parents: ___ married when _____ ages _____

___ separated when _____ ___ divorced when _____

___ deceased M or F _____ Step Parents: ___ married when _____

If child is adopted: Circumstance _____ Date of legal adoption _____

when child first in home _____ Does child know of adoption? _____

Living Arrangements:

Number of moves in child's life _____ Places _____ Dates _____

Present home: ___ condo ___ house ___ apartment ___ other: _____

Does the child share a room with anyone else? ___ Yes ___ No *If yes, with whom?* _____

If no, how long has he/she had own room? _____

Was the child ever placed, boarded, or lived away from the family? ___ Yes ___ No Explain: _____

Has either parent ever been separated from the child (i.e. long hospitalization, marital separation, divorce, etc.)? ___ Yes

___ No Explain: _____

Age of child at time of separation _____

BROTHERS and SISTERS: (indicate if step-brothers or step-sisters)

Name	Age	Sex	School or Occupation	Present Grade	Living at home (yes or no)	Use drugs or alcohol (yes or no)	Treated for drug abuse (yes or no)
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Others living in the home (and their relationship to child): _____

Does or did any member of the child's family have any problems with:

___ reading ___ spelling ___ math ___ speech ___ depression ___ anxiety

___ self-destructive behavior ___ schizophrenia ___ attempted or committed suicide

If yes, please explain: _____

Any major family changes (losses, illnesses, deaths, births, etc.)? _____

Age of child at time of change _____

Developmental History

Prenatal—Was child wanted? ___ Yes ___ No Planned for? ___ Yes ___ No

Paternal support and acceptance (explain): _____

Normal pregnancy? ___ Yes ___ No

If mother was ill or upset during pregnancy, explain: _____

Check any that were used during pregnancy: ___ Tobacco ___ Alcohol ___ Drugs

Birth: ___ Full term ___ Premature Length of labor: _____ hours/mins.

Type of delivery: ___ Normal ___ Breech ___ Cesarean ___ Other: _____

Condition of child at birth: _____

Was it necessary to give the infant oxygen? ___ Yes ___ No

At what age did your child: ___ Walk alone ___ Spoke single words ___ Sentences

At what age was your child toilet trained? _____ Was this difficult? ___ Yes ___ No

Has your child ever experienced injuries, illnesses, or hospitalizations apart from the normal childhood illnesses? ___ Yes ___ No Please describe (including age at time of experience: _____

Is your child currently taking any medications? ___ Yes ___ No *If yes, please explain:*

Name of Medication Dosage Frequency Reason

Has your child ever talked about or attempted suicide? ___ Yes ___ No Explain: _____

Is there history of sexual abuse or physical abuse? ___ Yes ___ No ___ Not sure

If yes, what age? _____

Do you have knowledge or think your child is using drugs, alcohol, and/or cigarettes?

___ Yes ___ No Explain: _____

Primary Care Physician (Name, Address, Phone Number): _____

FOR GIRLS:

Menstrual period: Age of first period _____ Problems: _____

Pregnancies: ___ Yes ___ No Terminated Pregnancies: ___ Yes ___ No *If yes, how many* _____

Spiritual Upbringing

Religion _____ Mother _____ Father _____

Please explain the role and importance of spirituality in child's upbringing _____

Is child's family affiliated with a spiritual/religious group? ___ Yes ___ No *If yes, describe:* _____

Would you like your spiritual/religious beliefs incorporated into the counseling? ___ Yes ___ No

Explain: _____

Education

	Name of School	City/State	Dates Attended:		Grades completed at this school
			From	To	
Preschool	_____	_____	_____	_____	_____
Elementary	_____	_____	_____	_____	_____
Middle school	_____	_____	_____	_____	_____
High school	_____	_____	_____	_____	_____

Types of classes: ___ regular ___ learning disability ___ continuation
___ emotionally handicapped ___ other: _____
What grade is he/she in? _____ How much does he/she like school? _____

Did child skip a grade? ___ Yes ___ No Repeat a grade? ___ Yes ___ No

If yes, what grade(s)? _____

Please describe any difficulties your child is experiencing in school, or has experienced in the past

Has your child had special testing in school? (If yes, what were the results? _____)

Psychological ___ Yes ___ No Vocational ___ Yes ___ No Special Ed ___ Yes ___ No

Has your child ever received psychiatric or counseling services? ___ Yes ___ No

If yes, please explain: _____

ACADEMIC PERFORMANCE:

Highest grade on last report card and subject/class? _____

Lowest grade on last report card and subject/class? _____

Favorite subject? _____ Least favorite subject? _____

Does child participate in extracurricular activities? ___ Yes ___ No

Explain: _____

List child's special interests, hobbies, skills: _____

What are child's educational aspirations? ___ quit school ___ graduate from high school
___ go to college ___ other

Social Development:

Relationship to siblings and peers: ___ individual play ___ group play ___ competitive
(check all that apply) ___ cooperative ___ leader ___ follower

How many friends does child have? ___ a lot ___ a few ___ none

Describe special habits, fears, or idiosyncrasies of the child: _____

Has the child ever had difficulty with the police? ___ Yes ___ No (If yes, explain) _____

Has child ever appeared in juvenile court? ___ Yes ___ No (If yes, explain) _____

Has the child ever been on probation? ___ Yes ___ No

From To Reason Probation Officer

Has child ever been employed? ___ Yes ___ No

Job Employer How long

ADDITIONAL COMMENTS—Please include any additional information that you feel would be helpful in the understanding of your child's situation.

Signature of person completing form _____ **Date** _____