Working with children and adolescents creates special challenges for doctors and therapists. Completing these questions about your child and your family will be very helpful in making an accurate diagnosis and providing the best care to your child. Please complete the questionnaire as best you can before arriving for your appointment. We will have an opportunity to discuss your answers at the time of your child's appointment. Every family's situation is unique. If the questionnaire does not provide an area for you to best describe your child's situation, there is room to provide input on the last page or feel free to include additional information.

Please leave this column blank for the clinician's use:

Child's Name_____

Birth date _____ Age _____ Gender: Male / Female

Person Completing Form: _____ Your relationship to child: _____

Child's pediatrician/physician? _____ Phone: _____
Have you notified child's physician of this appointment? ❍ Yes ❍ No

What is the primary reason for this referral?

_____
_____
_____
_____
_____
_____
_____
_____

Has your family experienced recent stresses?
❍Divorce or Separation ❍ Birth of another child ❍ Illness in family
❍ Death of a family member or close friend ❍ Parent fired or laid off
❍ Legal Problems ❍ Abuse or neglect ❍Moving ❍ Other

_____
_____
_____

Family History: What is the present marital status of this child's parents?

Mother: ❍ Married to child's father ❍Married ❍ Separated ❍ Divorced
❍ Other_____

Father: ❍ Married to child's mother ❍ Married ❍ Separated ❍ Divorced
❍ Other_____

Housing: ❍ Lives with parents ❍Lives with grandparents ❍ Other__ _____

Siblings (Please include all half and step-siblings):

Name_____ Age_____ Gender: Male / Female
Lives at home? ❍Yes ❍No

Name_____ Age_____ Gender: Male / Female
Lives at home? ❍Yes ❍No

Please leave this column blank for the clinician's use:

Name_____ Age_____ Gender: Male / Female
Lives at home? ❍Yes ❍No

Name_____ Age_____ Gender: Male / Female
Lives at home? ❍Yes ❍No

Does anyone else live in the home?
_____
_____
_____

Mother's History:

Mother's Name_____ Birth date _____Age_____
Highest Grade completed _____ Degree_____

Was this child's mother in any special education classes or treatment programs?
Please explain_____

In general, what grades did child's mother make? ❍A/B ❍B/C ❍C/D ❍D/F

Has child's mother ever thought she might have ADHD/be hyperactive? ❍Yes ❍No

Has child's mother experienced: ❍Depression ❍Anxiety ❍ Panic ❍ Bipolar D/O
❍Schizophrenia ❍ Anorexia ❍Bulimia ❍ Alcohol Abuse ❍ Drug Abuse
❍ Other _____

Has this mother's siblings or her own parents experienced any of these issues?
_____
_____

Father's History:

Father's Name_____ Birth date _____Age_____
Highest Grade completed _____ Degree_____

Was this child's father in any special education classes or treatment programs?
Please explain_____

In general, what grades did child's father make? ❍A/B ❍B/C ❍C/D ❍D/F

Has child's father ever thought she might have ADHD/be hyperactive? ❍Yes ❍No

Has child's father experienced: ❍Depression ❍Anxiety ❍ Panic ❍ Bipolar D/O
❍Schizophrenia ❍ Anorexia ❍Bulimia ❍ Alcohol Abuse ❍ Drug Abuse
❍ Other _____

Has this father's siblings or her own parents experienced any of these issues?
_____
_____

Child's History:

Please leave this column blank for the clinician's use:

Pregnancy: What was the length of pregnancy for this child? _____

Were there any known complications of pregnancy/birth?

_____

_____

Did child's mother use cigarettes/alcohol/drugs during pregnancy? ❍Yes ❍No
Number of days that child stayed in hospital after birth? _____
Did child make eye contact as an infant or toddler? ❍Yes ❍No
Did child meet all developmental milestones on time? Please elaborate:

Crawled @ _____ Sat up @ _____Walked @_____
First Word _____ @ _____
First sentence @ _____ Rode bike @_____
Toilet trained @ _____

Other milestone issues (advanced or delayed) _____

_____

_____

Childhood Diseases: Please check all that apply.

❍ Asthma ❍Anemia ❍Lead Poisoning ❍Mental Retardation
❍Encephalitis ❍Seizures ❍Epilepsy ❍Jaundice ❍Hydrocephalus
❍Cerebral Palsy ❍Heart Problems ❍Meningitis ❍Vision Problems
❍Hearing Problems ❍Emotional Difficulties ❍Other_____

Current Health: ❍Poor ❍Fair ❍Good ❍Excellent Present Weight: _____ lbs

Is the child in any way physically ill or handicapped at this time? ❍Yes ❍No
Please explain how your child is being treated for this handicap, illness or situation

_____

_____

_____

Is your child presently taking any medication(s)?

_____

Has child ever taken medication for emotional /behavioral problems? ❍Yes ❍No
Please explain. _____

_____

_____

_____

(Medication list on next page)

Name of Medication	Dose	Start Date	End Date	Effect: none, slight, improvement, side effects

Please leave this column blank for the clinician's use:

Does your child show any of these behaviors? ❍ Smoking ❍ Lying
❍ Use of Alcohol ❍ Use of Drugs ❍ Stealing ❍Being sexually active
❍ Setting Fires ❍Destroying Property ❍Hurting animals or younger children
Please explain any checked above:_____
_____
_____
Has child shown any cutting or self-harm behaviors? _____
_____

Where does this child attend school?_____
Does your child have a 504 or an IEP? _____
Where did child attend school previously (if anywhere)?
_____
_____

Does your child have any involvement or have they had previous involvement in court or with legal issues? _____
_____
_____

Do you have any other input from friends, family or teachers that you feel that the doctor needs to know about?
_____
_____

Parent/Guardian Signature:_____

Clinician Signature(s):_____

Today's Date: _____