Child and Teen History Questionnaire

Child's Name: ________________________ Age: _______ Birthdate: _________
Name child is called at home: ______________________________
Mother's/Guardian's Name: ________________________________ Age: _______
Father's/Guardian's Name: _________________________________ Age: _______
<u>If applicable</u>:
Step-mother's Name: ____________________________________ Age: _______
Step-father's Name: _____________________________________ Age: _______
Child's age when parents separated: _____________
If adopted, are birthparents involved in child's life? ________________________
In what way? ____
If adopted, at what age? ____

Names and ages of siblings:

______________________________ ______________________________
______________________________ ______________________________

Guardian, adoptive or step-parent: how old was the child when this person began caring for or living with the child? ______________________________________

Names and ages of step-siblings:
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

If applicable: If child changes houses, child's schedule:

____
____

Current school child attends: ______________________________ Grade: _____
Names of schools child has attended:
____ Grade: _________________
____ Grade: _________________

Since birth, how many times has family moved? ___________________________

What was child's birth like? Where was child born? Hospital or home birth?

____
____
____

What do you see as stressors on the child? ___________________________________
____
____
____
____

Medical History:
Birth: Any birth trauma Yes No If "yes", describe below.
All routine vaccinations Yes No
No vaccinations at all or some? Yes No
Serious injuries of accidents – Please describe and give dates:

____
____
____

Serious Illness ____
____

Eating:

Type of eater: Easily eats new foods Picky
Craves: ____
Favorite foods: ____

Favorite activities: ____

Feelings and behaviors you're concerned about:

aggression
hitting
kicking
biting
spits
screaming
tantrums
anger
violence
depression
sadness/crying/grief
shyness
school problems
not wanting to go to
school problems
studying
doesn't like teacher

teased or bullied by
other children
lying
stealing
bed-wetting (eneuresis)
soiling (encopresis)
nail-biting
hair-pulling/twisting
trouble making friends
difficulty playing with
other children
lonely
difficulty going to bed
nightmares
night terrors
difficulty falling asleep
difficulty waking up

eating problems
fights with siblings
jealousy
sneaky
worried
nervous
anxious
hurts animals
alcohol
drugs
fetal alcohol
drug addicted
hangs with wrong crowd
hyperactive
defiant
lazy
hurts objects

hurts children
bullying
gender issues
sexual identity issues
other: ____

Any concerns from teachers? Others? ____________________________________

____

Any diagnosis child has received: indicate how old child was when diagnosed.

ADD ______________
ADHD ____________
Learning Disability _______________
Oppositional disorder _____________
Asperger's Syndrome _____________
Other ___________________________

If yes to any above, please indicate who diagnosed the child, what treatments have been given, whether you feel those treatments have been helpful.

____
____
____

<u>History</u>

Sexual abuse
Physical abuse
Emotional/verbal abuse
Born with fetal alcohol syndrome
Born with physical or mental disabilities

<u>Strengths you see in the child</u>:

kind
honest
loves animals
responsible
organized
able to verbalize feelings
other: ____

<u>Types of discipline used in child's home(s)</u>:

discussing misbehavior
timeouts
yelling
removing favorite things
cancelling privileges
cancelling allowance
giving other consequences
uses rewards system
"grounding"
spanking

hitting other body parts
hitting with objects (belt, stick, brush)