

INITIAL HISTORY QUESTIONNAIRE

Form Completed by: _____ Date Completed: _____

Name of Child: _____ Age: _____

Date of Birth: _____ M F

FOR OFFICE USE ONLY

Client Profile ID #: _____

Presenting Issue #: _____

Household

Please list all those living in the child's home

Name	Relationship to child	Birth date	Health Problems

Are there siblings not listed? If so, please list their names and ages and where they live. _____

If mother and father are not living together or child does not live with parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent(s) not in the home? _____

Physician: _____ Last Seen: _____ Dentist: _____ Last Seen: _____

Birth History

Birth weight _____ Was the delivery vaginal? cesarean?

Was the baby born at term? Yes Early? Late? If cesarean, why? _____

If early, how many week's gestation? _____ Did the baby have any problems right after birth?

Prenatal Care

Did mother have any illness or problem with her pregnancy? Yes No Explain _____

During pregnancy, did mother Was initial feeding Breast? Bottle?

Smoke Yes No Drink alcohol Yes No

Use drugs or medication Yes No Did the baby go home with mother from the hospital?

What _____ When _____ Yes No Explain _____

General

Do you consider your child to be in good health? Yes No Explain _____

Does your child have any serious illness or medical condition? Yes No Explain _____

Has your child had serious injuries or accidents? Yes No Explain _____

Has your child had any surgery? Yes No Explain _____

Has your child ever been hospitalized? Yes No Explain _____

Is your child allergic to any medicine or drugs? Yes No Explain _____

Development

Are you concerned about your child's physical development? Yes No Explain _____

Are you concerned about your child's mental or emotional development? Yes No Explain _____

Are you concerned about your child's attention span? Yes No Explain _____

Is your child in school? Yes No Home schooled

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? Yes No If yes explain _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes, or has an IEP? Yes No If yes explain _____

Child's Past History

Does your child have, or has he/she ever had?

Chickenpox Yes No When _____

Frequent ear infections Yes No Explain _____

Problems with ears or hearing Yes No Explain _____

Nasal allergies Yes No Explain _____

Child's Past History (cont.)

Problems with eyes or vision Yes No Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia Yes No Explain _____
Any heart problem or heart murmur Yes No Explain _____

Does your child have, or has he/she ever had?

Anemia or bleeding problem Yes No Explain _____
Blood transfusion Yes No Explain _____
Frequent abdominal pain Yes No Explain _____
Constipation requiring doctor visits Yes No Explain _____
Bladder or kidney infection Yes No Explain _____
Bed-wetting (after 5 years old) Yes No Explain _____
(For girls) Has she started her menstrual periods? Yes No When _____
(For girls) Are there problems with her periods? Yes No Explain _____
Any chronic or recurrent skin problem
(acne, eczema, etc) Yes No Explain _____
Frequent headaches Yes No Explain _____
Convulsions or other neurological problem Yes No Explain _____
Diabetes Yes No Explain _____
Thyroid or other endocrine problem Yes No Explain _____
Any other significant problem Yes No Explain _____

Family History

Please indicate if any of the child's family members have had any of the following:

Deafness Yes No Who _____ Comments _____
Asthma Yes No Who _____ Comments _____
Tuberculosis Yes No Who _____ Comments _____
Heart attack (before 50 years old) Yes No Who _____ Comments _____
High blood pressure (before 50 years old) Yes No Who _____ Comments _____
High cholesterol Yes No Who _____ Comments _____
Anemia Yes No Who _____ Comments _____
Bleeding Disorder Yes No Who _____ Comments _____
Liver disease (Hepatitis) Yes No Who _____ Comments _____
Kidney disease Yes No Who _____ Comments _____
Diabetes (before 50 years old) Yes No Who _____ Comments _____
Bed-wetting (after 10 years old) Yes No Who _____ Comments _____
Epilepsy or seizures Yes No Who _____ Comments _____
Immune problems, HIV, or AIDS Yes No Who _____ Comments _____
Alcohol abuse Yes No Who _____ Comments _____
Drug abuse Yes No Who _____ Comments _____
Cancer Yes No Who _____ Comments _____
Mental illness Yes No Who _____ Comments _____
Mental retardation Yes No Who _____ Comments _____
Domestic Violence Yes No Who _____ Comments _____
Involvement with law enforcement Yes No Who _____ Comments _____
Additional family history _____

Child's Emotional / Behavioral

Has your child's behavior, thinking, and/or feelings made a turn for the worse since being on a particular medication, developing a physical illness or physical trauma? Yes No If yes, explain _____

Do you suspect that your child uses alcohol or drugs?

- No, I know for sure that my child doesn't use any of those things
- I am not sure, sometimes I wonder if my child uses alcohol or drugs
- Yes, I know for sure that my child uses alcohol or drugs

Child's Emotional / Behavioral (cont.)

Does your child act as if he or she is hearing voices that only he/she can hear?

- I don't know
- No
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

Does your child act as if he/she seeing things that only he/she can see?

- I don't know
- No
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

Please rate each the following emotions

My child seems <i>happy</i>	My child seems <i>sad</i>	My child seems <i>anxious</i>	My child seems <i>irritated</i>
<input type="checkbox"/> All of the time			
<input type="checkbox"/> Most of the time			
<input type="checkbox"/> Some of the time			
<input type="checkbox"/> Rarely	<input type="checkbox"/> Rarely	<input type="checkbox"/> Rarely	<input type="checkbox"/> Rarely
<input type="checkbox"/> None of the time			

Does your child have significant sleeping problems (for example: he sleeps too much or too little, or his sleep is often interrupted)?

- No
- Yes, but rarely
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

Does your child seem no longer interested in doing things that he/she usually enjoys (for example: talking to friends, fishing) ?

- No
- Yes, but rarely
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

Does your child ever talk about suicide or attempted suicide before? Yes No If yes explain _____

Does your child seem to worry too much about any particular member of your family's well being for no apparent reason?
 Yes No If yes, explain _____

Does your child complain about feeling sick or having an illness or disease that you know doesn't exist?
 Yes No If yes, explain _____

Does your child have trouble being apart from you or your home to the point that he/she becomes excessively worried?
 Yes No If yes, explain _____

Does your child fear being humiliated in social setting or situations?
 Yes No If yes, explain _____

Has your child ever experienced a trauma or shock in his lifetime that still bothers him/her?
 Yes No if yes, please explain _____

Child's Emotional / Behavioral (cont.)

Please indicate which of the following strong fears, if any, your child displays. These are fears that would usually cause him/her to feel very nervous, make him cry, throw tantrums, freeze, or cling to an adult.

- No fears
- A particular animal such as dogs
- A particular insect such as spiders
- Objects in the natural environment such as storms
- Seeing blood or an injury or receiving an injection
- Specific situation such as tunnels, heights, flying, etc.

Please rate the following behaviors

My child pays attention well

- All of the time
- Most of the time
- Some of the time
- Rarely
- None of the time

My child has respect for rules or for authority

- All of the time
- Most of the time
- Some of the time
- Rarely
- None of the time

My child is as active as any other child of his/her age

- All of the time
- Most of the time
- Some of the time
- Rarely
- None of the time

My child plays well with others

- All of the time
- Most of the time
- Some of the time
- Rarely
- None of the time

My child has consideration for the rights of others

- All of the time
- Most of the time
- Some of the time
- Rarely
- None of the time

Does your child have any history of sexual abuse as a

Victim Yes No

Perpetrator Yes No

Does your child have any history of physical abuse as a

Victim Yes No

Perpetrator Yes No

Has your child had any contact with law enforcement, Department of Juvenile Corrections, or Juvenile Probation before?

Yes No if yes, please explain _____

Does your child have any odd or unusual behavior that concerns you very much? Yes No If yes, explain _____

Please provide a list of your child's strengths:

- 1 _____
- 2 _____
- 3 _____
- 4 _____

Please provide a list of child's weaknesses:

- 1 _____
- 2 _____
- 3 _____
- 4 _____

By the signature below, I acknowledged that I have read and understood this questionnaire and provided information to the best of my knowledge and ability.

_____ Signature/Date

THANK YOU!