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CHILD & FAMILY QUESTIONNAIRE

Child's Name:	**Date of Birth:**

School:	**Grade:**

Parents/Guardians Name(s): ____

Address:____

City:__________________________ State:___________ Zip Code______

Phone Number: Home____________ Cell_____________ Email:_________________________

Emergency Contact: _______________________ Relationship: _______________________

Telephone #: ______________________ Email: _________________________________

Insurance Carrier:________________________ Insurance Plan ID:__________________________

Primary Insured Name: _____________________________

Teacher Name: _________________________ Email:___________________________________

If your child takes medication, did they receive their usual dosage before testing? Please include details:

____

____

FAMILY BACKGROUND

Who is in the home: Please describe Relationship to child: Parent, Sibling, Step Parent, Grandparent, Aunt, Paid Caregiver etc. and Siblings and Age of siblings.

____

____

____

What are the custody & visitation arrangements (if parents separated)?

____

____

Are there others involved with providing care on a regular basis, such as Day Care?

____

____

Put an (X) by any of the following changes that have occurred in the past 18 months:

( ) addition to family
( ) illness of family member
( ) family moved
( ) family member moved away
( ) parent(s) changed job
( ) parent(s) lost job
( ) death of family member
( ) child changed school
( ) financial problems
( ) other: specify___________________________
( ) parents separated
( ) parents divorced
( ) parent(s) remarried
( ) other losses

Please provide Details of any items checked above: i.e. if family moved why and what was the child's reaction:

____

____

____

Place an (X) by any of the following which may be concerns regarding your child:

( ) fighting
( ) cursing
( ) staring
( ) stealing
( ) crying
( ) afraid
( ) suspicious
( ) lying
( ) cutting
( ) fire setting
( ) argumentative
( ) nightmares
( ) depressed
( ) violent
( ) withdrawn
( ) confusion
( ) overactive
( ) suicidal
( ) sees things
( ) animal cruelty
( ) unusually happy
( ) uses alcohol
( ) loss of interest
( ) hallucinations
( ) sexual issues
( ) uses drugs
( ) bed wetting
( ) under active
( ) soiling
( ) pretends to be sick
( ) truancy from school
( ) running away from home
( ) careless in appearance
( ) falsely accusing others
( ) hearing voices
( ) sudden change in behavior
( ) walking in sleep
( ) sleep disturbance

Provide Details for items checked above:

____

____

____

AGENCY INVOLVEMENT

List other agencies involved with the family (Mental Health, DSS, DEC, school counseling) and details of involvement:

____

____

____

MISCELLANEOUS

Are there concerns about substance abuse? (alcohol or drugs)

____

Tobacco use? ____

Has your child been physically, emotionally or sexually abused?

____

Additional Comments:

____

____

____

MENTAL HEALTH HISTORY

Has your child been involved with previous Mental Health Services? Yes________ No_______

If yes, indicate where and when: ____

Counseling: _____Yes _____ No

If yes, indicate where and when ____

Psychiatric Hospitalization: _____Yes _____ No

If yes, indicate where and when ____

Psychological Testing: _____Yes _____ No

If yes, indicate where and when ____

Department of Social Services (DSS): _____Yes _____ No

If yes, indicate where and when ____

Department of Juvenile Justice: _____Yes _____ No

If yes, indicate where and when ____

Other: _____Yes _____ No

If yes, indicate where and when ____

FAMILY MENTAL HEALTH HISTORY

Has any family member: (indicate who)

( ) abused drugs ____

( ) abused alcohol____

( ) been physically abused____

( ) been sexually abused____

( ) attempted suicide____

( ) been arrested ____

( ) been hospitalized (psychiatric) ____

( ) mental health diagnosis mentally ill____

( ) been in jail ____

Please provide detailed information for any item checked above:

___

___

___

Mental Health Diagnosis for family members:

____

____

____

DEVELOPMENTAL AND MEDICAL HISTORY

Did mother have any physical or emotional abuse during pregnancy?
( ) Yes ( ) No If yes, describe:____

Did the mother have any health complications or contract any illnesses while pregnant____ _______________

Were there any complications during pregnancy or delivery, if yes please describe?
____

Developmental Milestones ___ delayed ___ average ___ early
Comments ____
____

How does your child deal with stress? ____
How does your child deal with anger? ____
How does your child deal with changes? ____

Medical Diagnosis and Relevant Medical History: ____
____
____
____

Sleeping Issues: ____
____

Eating Issues: ____
____

List all current prescription medications: ____
____
____

List all current herbal or over the counter supplements: ____________________________________
____
____

FAMILY DYNAMICS

Who makes the family decisions? ____

____

____

Who handles your child's punishments? ____

____

____

What do you do when your child has been extra good?______________________________________

What do you do when your child has been "bad"?____

Do disciplinarians agree on consequences? ____

Is there consistency in discipline/rules across multiple households? ___________________________

Do parents use physical punishment? ____

Does anyone provide care for your child? ____

Are there extended family involved? (who?) ____

____

____

SCHOOL

Were there any problems when your child started school? ( ) Yes ( ) No If yes, describe:

____

Did your child repeat any grades? ( ) Yes ( ) No If yes, which grades_

Is your child in special education classes? ( ) Yes ( ) No

Does your child have a(n) ___ 504 Plan ___ IEP What is plan for ?___________________________

Child's ability to learn: ( ) Slow ( ) Average ( ) Above Average ( ) Exceptional

Child's school grades are: ( ) Below Average ( ) Average ( ) Above Average

How well does your child get along with teachers?_____________________________________

Has your child had any behavioral problems at school? ( ) Yes ( ) No If yes, describe:

____

Was your child suspended this year?

____

Does child get along with other children at school?_______________________________________

____

SOCIAL SKILLS AND ACTIVITIES:

How does your child get along with peers?

____

____

Does your child have ______ friends. ___ a lot ___ a few ___ no

Prefers friends ___ male ___ female ___ younger ___ older ___ same age

How does your child resolve conflicts with peers?

____

Outside school where does your child see peers?

____

Is your child romantically involved with anyone?

____

Does your child help with routine chores around the house? ( ) Yes ( ) No Explain:

____

Does your child follow instructions at home? ( ) Yes ( ) No If no, explain:

____

What kinds of activities does your child enjoy?

____

____

____

What are your child's strengths?

____

____

Is your child involved with others in a group setting (groups, clubs, sports or church)?

____

____

What kind of things do you do as a family?

Amount of TV child views daily:

( ) less than 2 hours ( ) 2-4 hours ( ) 4-6 hours ( ) more than 6 hours

Favorite program:___________________Types of programs watched:_______________________

Amount of Video Game play daily:

( ) less than 2 hours ( ) 2-4 hours ( ) 4-6 hours ( ) more than 6 hours