Family First
Psychological Services

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CHILD/ADOLESCENT QUESTIONNAIRE

This questionnaire asks you to respond to a series of questions about your child and your family. This type of background information is helpful in understanding your child and ways we can help him/her. Please complete as best you can. When appropriate, it also will be helpful for you to bring copies of your child's recent report cards, standardized test results, and any previous educational, medical, or psychological reports.

IDENTIFYING INFORMATION

Child's Name: _____

Name of Person completing this form and relation to the above child: _____

_____

Child's School Name: _____ Grade: _____

Name of Parent/Guardian #1: _____ Occupation: _____

Name of Parent/Guardian #2: _____ Occupation: _____

Parents' marital status: ◯ Married ◯ Partnered ◯ Never Married ◯ Separated ◯ Divorced ◯ Widowed

** Please note: If child is under 18 and parents are separated/divorced, BOTH parents must consent for treatment by signing the Services, Policies, and Informed Consent Form.*

REASON FOR REFERRAL

Describe your main reason(s) for seeking services at this time:

_____

_____

_____

_____

_____

What would you like to change or improve by coming to FamilyFirst?

_____

_____

_____

_____

_____

CHILD'S BIRTH AND DEVELOPMENTAL HISTORY

Pregnancy: Was your child adopted? ◯ Yes ◯ No

Was the pregnancy planned? ◯ Yes ◯ No

Pregnancy length in months (or weeks):_____

During the pregnancy with this child, were there any medical difficulties and/or any prescription medications taken? ◯ Yes ◯ No

If *Yes*, please describe:

_____

Delivery and Post-delivery: Duration of labor: _____ hours

Type of labor: ◯ Spontaneous ◯ Induced

Type of delivery: ◯ Normal ◯ Breech ◯ Caesarean

Were there any delivery complications: ◯ Yes ◯ No

If Yes, please describe:

_____

Birth Weight: _____ lbs. _____ oz.

Child's condition at birth: ◯ Poor ◯ Good ◯ Excellent

Did your child have any postnatal complications? ◯ Yes ◯ No

If *Yes*, please describe: _____

_____

Developmental Milestones:

The following is a list of infant/preschool/school-age behaviors. For each behavior, please indicate if your child developed these skills: *Early*, *On Time,* or *Late*.

Behavior	Early, On Time, or Late	Behavior	Early, On Time, or Late
Rolled from stomach to back		Talked in sentences	
Sat without support		Began to read	
Crawled		Wrote first word	
Walked without assistance		Fed self without assistance	
Babbled		Dressed and undressed self	
Spoke first word		Bladder trained, day	
Pronounced letters and words clearly		Bladder trained, night	
Put several words together		Slept independently in own bed	

The following is a list of behaviors related to motor skill development. For each behavior, please mark the box to indicate if your child's early skills were: *Good, Average,* or *Poor* in relation to same-aged peers.

Coordination	Good	Average	Poor	Coordination	Good	Average	Poor
Walking	◯	◯	◯	Shoelace Tying	◯	◯	◯
Running	◯	◯	◯	Coloring/ Drawing	◯	◯	◯
Throwing	◯	◯	◯	Cutting with Scissors	◯	◯	◯
Catching	◯	◯	◯	Buttoning	◯	◯	◯
Riding Bicycle	◯	◯	◯	Handwriting	◯	◯	◯

Has your child ever received occupational therapy (OT) or speech therapy services?

◯ Yes ◯ No

If *Yes*, please describe: _____

Please describe any early indications of delayed or advanced abilities: _____

_____

FAMILY HISTORY/HOME LIFE

Child's Mother

Current age: _____ Age at the time of child's birth: _____

Highest level of education: _____

Occupation: _____

Medical problems: _____

Learning/behavior problems: _____

_____

Drug/alcohol history: _____

History of mental health problems (e.g., depression, anxiety, bipolar):

_____

Pertinent family history on maternal side (e.g., emotional, behavioral, learning, or substance abuse problems): _____

_____

Child's Father

Current age: _____ Age at the time of child's birth: _____

Highest level of education: _____

Occupation: _____

Medical problems: _____

Learning/behavior problems: _____

_____

Drug/alcohol history: _____

History of mental health problems (e.g., depression, anxiety, bipolar):

_____

Pertinent family history on paternal side (e.g., emotional, behavioral, learning, or substance abuse problems): _____

_____

Current Living Situation:

Who lives at home with the child? _____

If parents are separated/divorced, how old was the child at separation? _____

What is the current legal custodial agreement? _____

_____

What is the current visitation schedule? _____

_____

Please list your child's siblings below. Include name, age, relationship, and describe any history of behavior, learning, or mental health problems:

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

Describe any stressors that might be affecting your child now (death, divorce, trauma, etc.):

_____

_____

Does your child speak a language other than English in the home? ◯ Yes ◯ No

If *Yes*, please describe: _____

If English is a second language, at what age did your child begin learning English? _____

MENTAL HEALTH/MEDICAL HISTORY

Has your child received any previous therapy/counseling and/or undergone any psychological evaluations?

◯ Yes ◯ No If *Yes*, why, when, and with whom? _____

_____

Has your child been diagnosed with any behavioral, educational, medical, neurological, or psychiatric disorder(s), such as Attention Deficit/Hyperactivity Disorder (ADHD), Learning Disorder (LD), Anxiety, or Depression?

◯ Yes ◯ No If *Yes,* please describe: _____

_____

Is your child on any medication at this time? ◯ Yes ◯ No

If *Yes*, please list medication name, dosage, reason/purpose, how long on medication, and who prescribed: _____

_____

_____

Date of most recent medical exam:_____ Pediatrician Name: _____

Please describe all *current* and *previous* medical concerns, conditions, chronic illnesses, etc., including your child's age at the time of illness: _____

_____

_____

_____

Has your child ever been taken to the Emergency Room? ◯ Yes ◯ No

If *yes*, please describe why and how old he/she was at the time of the visit: _____

_____

Does your child have any allergies? ◯ Yes ◯ No

If *Yes,* please describe: _____

_____

Date of your child's most recent vision exam: _____

Does your child have any vision problems? ◯ Yes ◯ No

If *Yes*, corrected with: ◯ Glasses ◯ Contact lenses ◯ Vision therapy

Date of your child's most recent hearing exam: _____

Does your child have any hearing problems? ◯ Yes ◯ No

If *Yes*, please describe: _____

Did your child receive ear tubes due to multiple ear infections? ◯ Yes ◯ No

If *Yes*, at what age: _____

Does (or did) your child display any unusual sensitivity to things (sound, light, touch, etc.)?
◯ Yes ◯ No

If *Yes,* please describe: _____

_____

Does your child have any sleeping difficulties (trouble falling asleep, staying asleep, waking, etc.) ? ◯ Yes ◯ No If *Yes,* please describe:_____

_____

Does your child have any unusual eating patterns or habits? ◯ Yes ◯ No

If *Yes,* please describe: _____

EDUCATIONAL HISTORY

At what age(s) did your child attend preschool and/or kindergarten? _____

_____

Did your child ever have any difficulty separating from his/her caregiver? ◯ Yes ◯ No

If *Yes,* please describe: _____

Did teachers report anything unusual about his/her early school performance?
◯ Yes ◯ No If *Yes,* please describe: _____

_____

Did your child show significant strengths or weaknesses in any academic area from an early age? ◯ Yes ◯ No

If *Yes*, please describe: _____

_____

Has your child changed schools for reasons other than normal academic progression?
◯ Yes ◯ No If *Yes*, when and for what reason? _____

_____

Has your child skipped or repeated any grades in school? ◯ Yes ◯ No

If *Yes*, please describe: _____

_____

Other relevant information related to your child's school performance: _____

_____

_____

Please provide a copy of your child's most recent report card and/or list your child's most recent report card grades: _____

_____

_____

What subject(s) at school does your child most enjoy? _____

_____

What subject(s) at school does your child least enjoy? _____

_____

Has your child's school performance in (or attitude toward) school changed?

◯ Yes ◯ No If *Yes,* please describe: _____

_____

Does your child have any accommodations (i.e., 504 Plan or IEP) at school?

◯ Yes ◯ No If *Yes,* please describe: _____

_____

Do you have any concerns about your child's school or teachers?

◯ Yes ◯ No If *Yes,* please describe: _____

_____

Does your child have excessive absences and/or tardiness from school?

◯ Yes ◯ No If *Yes,* please describe: _____

_____

SOCIAL SKILLS

About how many close friends does your child have?

◯ None ◯ One ◯ Two or three ◯ Four or more

About how many times a week does your child do things with friends outside of regular school hours? _____

Compared to others of the same age, how does your child get along with other children?

◯ Below Average ◯ Average ◯ Above Average

Compared to others of the same age, how does your child interact with adults?

◯ Below Average ◯ Average ◯ Above Average

Who does your child prefer to play with? ◯ Family ◯ Alone

◯ Younger ◯ Same age ◯ Older Children

Does your child participate in any extracurricular activities and/or social organizations?

◯ Yes ◯ No If *Yes*, please describe: _____

_____

What are your child's favorite play activities when with friends? _____

_____

What are your child's favorite play activities when alone? _____

_____

Does your child display any unusual or repetitive play activities?

◯ Yes ◯ No If *Yes*, please describe: _____

_____

EMOTIONS/BEHAVIOR

How concerned are you about your child with regard to the following *emotions*? Please check your rating below from 1 (*not at all*) to 5 (*extremely*).

Sadness	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Irritability	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Worry	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Anger	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Frustration	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Self-Confidence	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5

Please explain any ratings of 3 and above: _____

_____

_____

Do you have any concerns regarding your child's *behavior* at home, in public, or at school?

◯ Yes ◯ No If *Yes*, please describe: _____

_____

_____

How do you handle discipline in your family? _____

_____

_____

Do you feel these methods are successful in managing your child's behavior?

◯ Yes ◯ No

Please share your child's strengths: _____

_____

Is there any other information that you think may help us in understanding and working with your child? _____

_____

_____

_____