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LIFE HISTORY QUESTIONAIRE: CHILD

CHILD

Child Name: ________________________________Sex: _________ Age: __________DOB: ____________

Biological Child: ☐ No ☐ Yes If adopted, at what age? ___________________ Foster since _______________

Parent/Guardian(s) Names: ____

Primary reason you are concerned about your child? ____

____

SYMPTOM/ PROBLEM CHECKLIST

Check any symptom that is a concern. How long has it been a problem?

☐ Sleep problems
☐ Lack of interest in activities
☐ Unassertive
☐ Fatigue/ low energy
☐ Concentration problems
☐ Appetite/ weight changes
☐ Withdrawal
☐ Morbid thoughts
☐ Suicidal thoughts or threats
☐ Suicidal plans/ attempts
☐ Mood swings
☐ Depression
☐ Changed level of activity
☐ Cries easily
☐ Excessive worry/ fearfulness
☐ Anxiety or panic attacks
☐ Social fears, shyness
☐ Separation problems
☐ Bedwetting/ soiling
☐ Odd beliefs/ fantasizing

☐ Lying
☐ Trouble with the law
☐ Running away
☐ Truancy, skipping school
☐ Hurting others sexually
☐ Alcohol/ drug use
☐ Argumentative/ defiant
☐ Swears
☐ Blames others for mistakes
☐ Nightmares
☐ Frequent tantrums
☐ Resistive to change
☐ School refusal
☐ Perfectionism
☐ Odd hand/ motor movements
☐ Hallucinations
☐ Stealing
☐ Being destructive
☐ Fire setting
☐ Hurting others/ fighting

☐ Acts as if has no fear
☐ Short tempered
☐ Easily annoyed/ annoys others
☐ Discipline problem
☐ Angry and resentful
☐ Forgetful/ memory problems
☐ Short attention span
☐ Aggressive behavior
☐ Can’t sit still
☐ Not interested in peers
☐ Picked on/ bullied by peers
☐ Talks excessively/ interrupts
☐ Easily distracted
☐ Irritable
☐ Impulsive
☐ Difficulty following rules
☐ Problem completing schoolwork

BROTHERS & SISTERS

Name	Sex	Age	Relationship to Child (full,step,half,foster)

SCHOOL HISTORY

Present School: ____Grade: ________________

Has child ever repeated any grade?

☐ No ☐ Yes (specify): ____

Is child receiving special education services?

☐ No ☐ Yes (specify): ____

Please describe academic or other problems your child has had in school: ____________________________

____

____

CHILD DEVELOPMENTAL & MEDICAL HISTORY

In the first two years of life, did this child experience:

☐ Separation from mother	☐ Chronic illness
☐ Out of home care	☐ Parental stress
☐ Chronic pain	☐ Neglect
☐ Disruption in bonding	☐ Abuse
☐ Depression of mother	☐ Parental Illness

If child's medical history included any of the following, please note the age when the incident or illness occurred and any other pertinent information:

Childhood diseases: ☐ No ☐ Yes (specify) ____

Operations: ☐ No ☐ Yes (specify) ____

Hospitalizations: ☐ No ☐ Yes (specify) ____

Head injuries: ☐ No ☐ Yes (specify) _________________Unconscious? ____________

Convulsions: ☐ No ☐ Yes (specify) ____

Your overall rating of child's health:

☐ Good ☐ Moderate ☐ Poor

Date of last medical exam? ____

Name of Physician: ____

Present illness(es) being treated for: ____

Medications child is taking on regular basis: ____

____

List any medicines previously used for emotional problems: were they helpful? ______________________

____

Allergies to any medication, food or environment conditions? ______________________________

About how many hours per day does this child engage in screen time activities? (TV, phone, video games, etc.) ____

Are you afraid someone you know may injure/harm this child

☐ No ☐ Yes (specify): ____

Any previous psychological or psychiatric treatment?

☐ No ☐ Yes: Whom/Where: ______________________________When? __________

Any previous testing (school/psychological)?

☐ No ☐ Yes: Whom/Where: ______________________________When? __________

FAMILY PSYCHIATRIC HISTORY

Please indicate which of the following is true for yourself or any family member:

	Child (Client)	Mother	Father	Sibling	Grandparent	Aunt	Uncle
Depression							
Bipolar Disorder							
Suicide Attempts							
Anxiety							
Drug/Alcohol							

Has child witnessed domestic violence?

☐ No ☐ Yes (specify): ____

How is your child disciplined? Please list method & frequency of use: __________________________

____

LIFE STRESSORS/ TRAUMA HISTORY

Has your child been verbally abused?

☐ No ☐ Suspected ☐ Yes (specify): ______________________________________

Has your child been physically abused?

☐ No ☐ Suspected ☐ Yes (specify): ______________________________________

Has your child been sexually abused?

☐ No ☐ Suspected ☐ Yes (specify): ____

Other stressors or traumas? ____

____

What are your child's strengths? ____

____

In three words, describe your child:

1. ______________________________________

2. ______________________________________

3. ______________________________________