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CHILD INFORMATIONAL QUESTIONNAIRE

Client's Name: _____ Birth date: _____ Age: _____

Gender: ☐ F ☐ M

Form Completed by: ☐ Mother ☐ Father Other: _____

Custody/Guardianship

Mother's Name: _____ ☐ Resides with Custody: ☐ Yes ☐ No ☐ Unknown

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Email: _____ Occupation: _____ Age: _____

Father's Name: _____ ☐ Resides with Custody: ☐ Yes ☐ No ☐ Unknown

If address is not the same as above:

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Email: _____ Occupation: _____ Age: _____

Other Guardian/Caretaker: _____ ☐ Resides with Custody: ☐ Yes ☐ No ☐ Unknown

Relationship: ☐ Grandparents ☐ Other Family ☐ Foster Parents ☐ Friend ☐ DCF Other: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent Relationship Status: ☐ Married ☐ Never married ☐ Separated ☐ Divorced ☐ Widowed

If divorced, who has legal custody: _____

Siblings/including step-siblings and half siblings

Name:	Age	Gender
1.		
2.		
3. ss		
4.		

Other people living in the home (cousins, grandparents)

1.

2.

DCF involvement, past or present: ☐ Yes ☐ No

Presenting Problem

What is it about your child that concerns you?

When was it first noticed?

What have you tried to help solve the problem? What has been helpful? What has not worked?

What have you been told with regard to the problem?

How do you think counseling might be able to help?

Family History

Current family dynamics and family factors that contribute to child's presenting problem(s) and/or concerns:

Impact of your child's presenting issues on the family:

Significant Life Events that may have impacted child's current problem(s):
(e.g.. Death of loved one, move/school change, divorce, trauma, medical problem for any family member, family issues)

Please indicate whether there are any relatives of the child, including parents, grandparents, aunts, uncles and cousins who have the same or a similar problem for which you are seeking evaluation. Also indicate for these persons whether there are serious, chronic or recurrent illnesses. (Please be as specific as possible, giving relationship to child, age and problem).

Mother's Family:

Father's Family:

Describe your child's relationships with his parents and siblings:

What are your child's strengths?

Educational History

School Currently Attending: _____ Phone Number: _____

Current Grade: _____ Spec. Ed. ☐ Yes ☐ No

What educational challenges, if any, has your child experienced in the past, when did they first start and what has been found to be helpful/not helpful?

Describe your child's peer relationships:

Has your child ever been in Special Education or remedial classes – when, where and what kind?

Prior Evaluations:

	Date	Evaluator	Facility
☐ Psychological testing	_____	_____	_____
☐ Psychiatric eval.	_____	_____	_____
☐ Speech/Language eval.	_____	_____	_____
☐ O.T. evaluation	_____	_____	_____
☐ Other:			

Medical History

List any known medical issues (past and present):

Medication

Child taking medication: ☐ YES ☐ NO

Current Medication	Prescribing MD	Dosage	How often is it taken?	Date Begun	Purpose	Outcome

Current OTC (Over–the-Counter), Vitamins, Dietary and/or Herbal Supplements:

Past Medication	Prescribing MD	Dosage	How often is it taken?	Date Begun	Purpose	Outcome

List any known allergies to:

Medications: _____

Foods: _____

Insects (Bees, etc.): _____ If yes, is an Epipen prescribed? _____

Other: _____

Describe any significant medical history that may be contributing to your child's current problems?

Psychological History

Current and Prior Services:

Provider	Type of Treatment	Dates	Reason

Check any of the following that apply:

- ☐ Poor appetite
- ☐ Poor sleep
- ☐ Fatigue
- ☐ Apathy
- ☐ Down mood
- ☐ Worry
- ☐ Physical pain
- ☐ Tension
- ☐ Mood swings
- ☐ Loses temper
- ☐ Argues a lot
- ☐ Easily annoyed
- ☐ Defiant
- ☐ Blames others
- ☐ Angry
- ☐ Resentful
- ☐ Spiteful
- ☐ Steals
- ☐ Suicidal thoughts
- ☐ Runs away (2X+)
- ☐ Lies
- ☐ Sets fires
- ☐ Truancy
- ☐ Poor peer relationships
- ☐ Forced sex
- ☐ Use weapon
- ☐ Physical fights
- ☐ Bullies others
- ☐ Cruel (to humans or animals)
- ☐ Paranoia
- ☐ Delusional
- ☐ Hallucinations
- ☐ Loose assoc.
- ☐ Catatonia
- ☐ Inappropriate Affect
- ☐ Flat affect
- ☐ Dissociative
- ☐ Memory impaired
- ☐ Fidgets
- ☐ Distracted
- ☐ Blurts out answers
- ☐ Impatient
- ☐ Poor attention
- ☐ Talks excessively
- ☐ Unfinished activities
- ☐ Interruptive
- ☐ Loses things
- ☐ Difficulty taking turns
- ☐ Dangerous behaviors
- ☐ Organization difficulties
- ☐ Often leaves seat
- ☐ Specific fears
- ☐ Self conscious
- ☐ Needs reassurance
- ☐ Encopretic
- ☐ Eneuretic
- ☐ Withdrawn
- ☐ Poor eye contact
- ☐ Language delay
- ☐ Repetitive language
- ☐ No fantasy play
- ☐ Inflexible rituals
- ☐ Repetitive movement
- ☐ Social delay
- ☐ Lack of emotion
- ☐ Idiosyncratic language
- ☐ Impaired nonverbal
- ☐ Preoccupied with objects
- ☐ Selective mutism
- ☐ Vocal tics
- ☐ Motor tics
- ☐ Fear of dying
- ☐ Racing heart
- ☐ Sweating
- ☐ Chest pain
- ☐ Dizzy/faint
- ☐ Short breath

Other:

Has there been any history of abuse (physical, sexual, emotional)? ☐ Yes ☐ No

Is there any history of domestic violence in the home? ☐ Yes ☐ No

Has there been any history of suicidal ideation? ☐ Yes ☐ No

Has there been any previous suicidal attempts? ☐ Yes ☐ No

Has there been any history of aggressive behaviors toward others? ☐ Yes ☐ No

Describe any other information you believe will be helpful in creating the most effective treatment plan for your child: