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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.		
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
<input type="checkbox"/> Psychological testing	_____	_____	_____
<input type="checkbox"/> Psychiatric eval.	_____	_____	_____
<input type="checkbox"/> Speech/Language eval.	_____	_____	_____
<input type="checkbox"/> O.T. evaluation	_____	_____	_____
<input type="checkbox"/> 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:

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

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: