CHILD/ADOLESCENT HISTORY QUESTIONNAIRE

This questionnaire is to be completed by the parent or guardian. Patients 13 y/o and older have the right to confidentiality in the state of Washington. This form has been designed to provide necessary information for our initial appointment. Please feel free to add any information you feel may be helpful. All information is strictly confidential and can only be released with your permission.

Name *(Last, First, M.I.):* ☐ M ☐ F ☐ Other	**DOB:** **AGE:**
Address:	**Phone #**
Person completing this form and relation to child/adolescent:	
Who referred you?:	**Reason for referral:**
Place of Birth:	**How long in WA?**
Any vision or hearing difficulties?	**Current Ht./Wt.:**
Pt.'s Pediatrician:	**Pt.'s Therapist:**
Who lives in the home with you? (Please include all family member first and last names and ages)	

SCHOOL & PAST PSYCHIATRIC/MEDICAL INFORMATION

Current school, grade & teacher's name:		
Current issues at school:	☐ Failing grades	☐ Held back any grades? If so, which grade(s)?
	☐ IEP	☐ Gifted program
	☐ 504-B plan	☐ Special Ed. Classes

List any medical problems that other doctors have diagnosed, or past surgeries:

Please list any history of psychiatric treatment, including counseling, inpatient hospital stays, ER visits, past providers

Year	Reason	Hospital/Counselor

Please indicate if your child is experiencing any of the following difficulties:

☐ Anxiety	☐ Nightmares	☐Alcohol/Drug use	☐Impulsive Behaviors	☐Trouble with focus/concentration	☐Skin picking
☐Social Anxiety	☐Sadness	☐Aggressive Behaviors	☐Soiling accidents (refusal, withholding, fear/anxiety)	☐Obsessive or rigid behaviors	☐Oppositional or defiant behaviors
☐Insomnia	☐Isolation	☐Difficulty making friends	☐Vocal or motor tics (grunts, squeals, eye blinks, throat clearing)	☐Problems with eating	☐Tantrums/ Meltdowns
☐Trouble waking up in a.m.	☐Wetting accidents	☐History of abuse (physical, emotional, sexual)	☐Hyperactivity	☐Problems controlling temper	☐Sensory issues (over or under reacts to lights, sounds, tastes, textures, smells)

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

PREGNANCY/DEVELOPMENT/TRAUMA & LOSS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Birth and Delivery	☐ Premature ☐ Late ☐ Full Term Any difficulties during pregnancy?				
	Difficulties following the delivery? ☐ Yes ☐ No				
	Exposure to drugs or alcohol during pregnancy? ☐ Yes ☐No				
	Describe temperament as an infant (e.g., easy-going, irritable, passive, difficult to soothe, etc)				
	SPEECH & LANGUAGE				
	Coo and Babble	☐ Early	☐ On Time	☐ Late	☐ Not Yet
	Respond to name	☐ Early	☐ On Time	☐ Late	☐ Not Yet
	Say first word	☐ Early	☐ On Time	☐ Late	☐ Not Yet
	Speak in sentences	☐ Early	☐ On Time	☐ Late	☐ Not Yet
	Follow simple directions	☐ Early	☐ On Time	☐ Late	☐ Not Yet
	Has your child had to see a speech therapist? ☐ Yes ☐ No				
	MOTOR SKILLS				
	Roll over	☐ Early	☐ On Time	☐ Late	☐ Not Yet
	Sit alone	☐ Early	☐ On Time	☐ Late	☐ Not Yet
	Stand alone	☐ Early	☐ On Time	☐ Late	☐ Not Yet
	Walk alone	☐ Early	☐ On Time	☐ Late	☐ Not Yet
	Write legibly	☐ Early	☐ On Time	☐ Late	☐ Not Yet
	SOCIAL/EMOTIONAL				
	Smile at others	☐ Early	☐ On Time	☐ Late	☐ Not Yet
	Laugh aloud	☐ Early	☐ On Time	☐ Late	☐ Not Yet
	Show affection	☐ Early	☐ On Time	☐ Late	☐ Not Yet
	Engage in pretend play	☐ Early	☐ On Time	☐ Late	☐ Not Yet
	First friendship	☐ Early	☐ On Time	☐ Late	☐ Not Yet
	Control feelings when upset	☐ Early	☐ On Time	☐ Late	☐ Not Yet
	Show responsibility	☐ Early	☐ On Time	☐ Late	☐ Not Yet

Trauma/Loss Please check if the pt. has experienced any of the following types of trauma or loss	Emotional abuse	☐ Yes ☐ No	Sexual abuse	☐Yes ☐ No
	Physical abuse	☐Yes ☐ No	Violence in home	☐Yes ☐ No
	Parental substance abuse	☐Yes ☐ No	Teen Pregnancy	☐Yes ☐ No
	Live in foster home	☐Yes ☐No	Loss of a loved one	☐Yes ☐ No
	Placed for adoption	☐Yes ☐ No	Parental Illness	☐Yes ☐ No
	Teen pregnancy	☐Yes ☐ No	Homelessness	☐Yes ☐ No
	Neglect	☐Yes ☐ No	Financial Problems	☐Yes ☐ No

Drugs	Any current or past use of recreational drugs?	☐ Yes	☐ No
	If yes, please list drugs pt. has experimented with or currently using:		
History of Head Trauma	Has pt. ever hit their head or been hit in the head?	☐ Yes	☐ No
	Ever seen in Emergency Room following a head injury?	☐ Yes	☐ No
	Ever lose consciousness following a head injury?	☐ Yes	☐ No
	Have you experienced changes in focus, concentration, headaches, dizziness, difficulty reading or writing, poor judgment, increased anger episodes since hitting your head? (please circle which symptoms are applicable to you)	☐ Yes	☐ No

FEMALE ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No

OTHER PROBLEMS

Check if the pt. has or has had, any symptoms in the following areas to a significant degree

☐ Headaches	☐ Abdominal pain	☐ Appetite changes
☐ Changes to vision	☐ Chronic diarrhea/constipation	☐ Significant weight changes
☐ Chronic Ear infections	☐ Frequent urination	☐ Easily bruised
☐ Problems with hearing	☐ Allergies	☐ Rashes
☐ Chronic strep throat	☐ Seizure activity	☐ Heart Murmur, Heart abnormalities, Heart Arrhythmia
☐ Breathing issues/asthma	☐ Cold or Heat intolerance	

FAMILY MENTAL HEALTH HISTORY

PLEASE LIST ANY MENTAL HEALTH DISORDERS IN YOUR IMMEDIATE FAMILY BELOW (MOM, DAD, GRANDPARENTS, SIBLINGS, AUNTS, UNCLES)	
Mental Health Diagnosis	**Family Member(s)**
Bipolar Disorder	
Depression	
Anxiety	
OCD	
Schizophrenia	
Autism/Asperger's	
Drug or Alcohol Abuse	
Anger Issues	
Suicide (completed/attempted)	
ADHD	

PLEASE INCLUDE ANY OTHER CONCERNS OR INFORMATION YOU FEEL WOULD BE HELPFUL FOR ME TO KNOW THAT YOU MAY NOT WANT TO DISCUSS IN THE PRESENCE OF YOUR CHILD: