PREMIER PSYCHOLOGICAL CENTER, Inc

CHILD QUESTIONNAIRE (ages 17 and under) ***PLEASE PRINT****

Information requested in the questionnaire will be helpful in obtaining a comprehensive evaluation. Please complete it carefully and completely. If your child is on medication, medications should be taken on the day of the evaluation. Evaluations may not be completed for children who have not taken medications and the appointment would need to be rescheduled.

IDENTIFYING INFORMATION

Today's Date____________________________________

Child's Name ____

Accompanying Parent/Guardian____

Relationship to child ____

Child's Birth Date____________________ Age ______ Male / Female (circle one)

Address____

Home phone__________________________________

Parent Work phone__________________________________ Cell____

PLEASE PRINT*

Reason for Referral (What symptoms/behavior are you concerned about?) ___________________________________

____

____

____

____

____

FAMILY HISTORY

Please list people that live in the child's current home (including step-parents and grandparents if living in a child's household):

Name	Relationship	Age	Receives disability funds? Or source of income?	Occupation

Are any of the children in this family adopted? **Yes / No** ____

Are the parents married? **Yes /No** (circle one) If married, how long have they been married? ______________________

If separated or divorced, how long? ____________________ Number of marriages: ___________________________

Current or recent Family stressors that is affecting child (i.e. divorce, death, unemployment, Illness)? Explain

____

____

____

History of immediate family problems (i.e. addiction, legal problems, mental health issues)--include parents, siblings, grand-parents ____

____

____

DEVELOPMENTAL HISTORY

Were there any complications during pregnancy (such as illnesses, accidents, bleeding, diabetes)? If so, please explain:

____

____

____

Did you use drugs, alcohol, or cigarettes during the pregnancy? **Yes / No** If yes, explain what type of drugs:

____

____

Was your child born late or prematurely? **Yes / No** If yes, explain: ______________________________________

____

Child's weight at birth________________________

Describe any problems after birth (jaundice, etc.)____

____

When did your child attain major developmental milestones (list approximate ages):

Milestones	**Age**	**Milestones**	**Age**
Walking		Crawling	
Talking/speech		Sleep through night	
Bladder control-days		Bladder control-nights	
Bowel control-days		Bowel control-nights	

Were there any behavior problems as a toddler (for example: excessive fear of separation, etc.)? **Yes / No**

If yes, describe: ____

____

MEDICAL HISTORY

List any medications that your child is taking at this time. Give the name, dosage, and reason for being prescribed:

Name of Medication	Dosage	Reason for Taking?	Taken Today? If yes, what time?
			Yes / No Time?
			Yes / No Time?
			Yes / No Time?
			Yes / No Time?

If this child must take medications, is he/she able to do so without your help? **Yes / No**

Indicate whether your child has been DIAGNOSED with any of the following conditions or problems. If yes, please explain in the space provided:

Medical Condition/Problem	Yes / No	If yes, when diagnosed? Explain (i.e. ever hospitalized)?
Vision-- Wears glasses or contacts?	Yes / No	
Mental Retardation	Yes / No	
ADHD	Yes / No	
Epilepsy, seizures	Yes / No	
Headaches	Yes / No	
Allergies, asthma	Yes / No	
Extreme weight gain or loss	Yes / No	
Unusual nervousness, tics	Yes / No	
Irritability, anger, extreme moodiness	Yes / No	
Anxiety, excessive fear	Yes / No	
Insomnia, poor sleep, nightmares, night terrors	Yes / No	
Bed-wetting	Yes / No	

When did he/she last have a complete physical exam and were the findings normal? **Yes/ No** If no, please explain:
____

____

Physician's Name____

Has your child had any major illnesses, accidents, or surgeries? **Yes / No** If yes, explain:
____

____

Does child have a history of illegal drug use? **Yes/No** If yes, explain

Type of Drug (i.e. marijuana, alcohol)	**When use first began?**	**How often and how much used**	**Date of last use**

Has your child ever been arrested? **Yes/No** If yes, explain

Date arrested?	**Reason**	**How long incarcerated**	**Current probation? Yes/No**

If not arrested, any criminal activity (stealing/gangs/running away?). Explain ________________________________

____

____

____

Any other behavior difficulty (running away, cruelty to animals/sexual misconduct)? Explain
____

____

____

ACADEMIC HISTORY

Current Grade__________ Repeated any grades?: **Yes / No** If yes, which grade(s)? ___________________________

What were the child's most recent grades on report card? ____

Any diagnosed learning issues (Dyslexia, mental retardation, LD etc.)?

____

____

Special Education Services with an IEP: **Yes / No**

If yes, what type? (i.e. LD, MID, EBD, speech) How often do they receive special-education (i.e. daily/3 times a week/co-teaching)?

____

____

____

Current or past **speech**/language therapy: **Yes / No** If yes, when

School suspensions (ISS, OSS): **Yes/No**. If **yes**, complete chart below

Date Suspended	**Type of suspension (ISS/OSS/detention)**	**Reason for Suspension**

Describe the child's relationships with teachers and students: ______________________________

____

____

School Counseling (current or past?) **Yes/No.** If yes, when? ___________________________ Was it individual or group?

____

What was the reason?____

____

____

PSYCHIATRIC HISTORY

Does this child have a mental health diagnosis? **Yes / No** If yes, complete the following

Diagnosis	Date diagnosed?	List type of CURRENT treatment, if any? (i.e meds/counseling/none)	List type of PAST treatment, if any? (i.e meds/counseling/none)	Treatment helpful? Yes/No

Has your child ever been placed in a psychiatric/inpatient hospital? Please explain WHEN and WHY:
____

____

____

____

Does your child ever seem depressed? **Yes / No** If yes, how can you tell?____________________________

____

____

Does your child ever do things which are dangerous to himself/herself ? **Yes / No**

If yes, please describe:____

____

Does your child ever do things which are seriously dangerous to others ? **Yes / No**

If yes, please describe: ____

Does he/she have trouble controlling his/her temper? **Yes / No** If yes, (a) how often does he get angry?____

(b) What does your child say/do when angered?_______________________________________

____

DAILY ACTIVITY HISTORY

Describe the child's daily activities. How does spend the majority of days and nights?
____

____

____

What chores is he/she supposed to do?
____

Does child need assistance or reminders to complete chores?

____

____

What sort of foods/snacks does child prepare on the stove?

How does child do in bathing, dressing, and personal grooming?

Does child do anything to earn money? Any part-time jobs? Describe.

What types of activities or hobbies does he/she enjoy (i.e. video games, internet, football)?

____

____

____

____

Is it difficult for him/her to make and keep friends? **Yes / No** If yes, why?_____________________________

____

____

How often does child visit friends or have them visit? What types of things does child do with friends?
____

____

____

Does child have a driver's license? **Yes/No** How does he/she get where he/she needs and/or wants to go?
____

____

Any additional comments

____

____

____

____

____

Do Not write below this line. For Official Use Only.

Affect:

Orientation:

Reasoning:

Physical ID:

Express:

R/R Memory:

Receptive:

Effort:

Gross/Fine Motor:

Est. Intell.

Insight & Jud:

Attention:

Additional Notes:

Initial Dx:
I
II
III
IV
V

Anaylsis: