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CHILDREN'S HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to obtain a comprehensive picture of your child's background. In scientific work, historical records are necessary, as they permit a more thorough and realistic developmental understanding of your child's current diagnosis. By completing these questions as fully and as accurately as you can, you will facilitate your child's therapeutic program. However, if there are any questions you feel are inappropriate to answer on paper, you may discuss them privately with the therapist.

If you do not desire to answer any specific question, merely write, "Do not care to answer."

Child's Name: _____ DOB: _____

Mother's Name: _____Age: _____ Home Phone: _____

Address: _____

Work Phone: _____ Cell Phone: _____

Father's Name: _____Age: _____ Home Phone: _____

Address: _____

Work Phone: _____ Cell Phone: _____

Stepparents' Names and Ages: _____

_____

Have you sought guidance regarding these or similar problems in the past? ____ yes ____ no

If so, therapist's name and/or clinic: _____

When? _____ For how long? _____

Developmental History

1. Pregnancy and Delivery

a. Mother's health and mood compared with other pregnancies: _____

b. Was this pregnancy planned by both parents? _____

c. Birth weight and infant's health: _____

d. Any problems with pregnancy? ____ yes ____ no If yes, explain: _____

_____

e. Any problems with perinatal events or use of drugs, tobacco, or substances during pregnancy?

____ yes ____ no If yes, explain: _____

_____

2. Feeding and Nutrition

a. How long did mother nurse this baby? _____

b. How long did child use bottle/formula? _____

c. Any problems feeding child? ____yes ____ no If yes, explain: _____

d. Fed on demand or on a schedule? _____

e. Current appetite and eating habits: _____

f. Any food allergies? ____ yes ____ no If yes, list: _____

3. Sleep Patterns

a. During the first year, what were your child's sleep patterns? _____

_____

b. From birth to age 5, any nightmares, sleepwalking, or head-banging? ____ yes ____ no

c. From age 5 to now, describe any bed-wetting or other problems: _____

_____

4. Motor Development and Speech

As closely as you can recall, at what age did your child first display the ability to:

a. Turn over in crib _____ b. Sit up with help _____

c. Stand alone _____ d. Walk without support _____

e. Speak any words _____ f. Speak in sentences _____

g. Current (1) speech or (2) hearing functioning: ___ poor ___ adequate ___ excellent

h. Stop wearing diapers during the day _____

i. Consistently sleep through the night without bed-wetting _____

5. Bowel and Bladder Training

a. How was this training accomplished? _____

b. Any recent problems? ____ yes ____ no If yes, what and when: _____

_____

6. Physical Health

a. List dates of significant illness, accidents, and hospitalizations: _____

_____

_____

b. General health/handicaps or disabilities, including hearing, vision, or intellectual deficits:

_____

c. Allergies/adverse reactions (and current status): _____

d. Current medication and dosage: _____

e. Frequent colds, flu, fevers? ____ yes ____ no

f. Any history of convulsions or seizures? ____ yes ____ no

g. How does your child feel about his/her body? _____

h. Are immunizations up to date? ____ yes _____ no Adverse reactions? ____ yes _____ no

_____

i Any history of witnessed or experienced trauma including abuse, neglect, violence or sexual assault?

_____ Yes _____ No If yes, please explain: _____

_____

Risk Factors for Suicide and Prevention

1= Not at all 2 = just a little 3= about half the time 4= much of the time 5= all the time

Individual Risk Factors	Yes	No
Mental health problems including depression, bipolar disorder, and anxiety disorders	☐	☐
Alcohol and other substance use problems	☐	☐
Loss (due to death, relationship, job, or status)	☐	☐
Poor impulse control	☐	☐
Feelings of hopelessness, powerlessness, or desperation	☐	☐
History of trauma or abuse (e.g. physical, mental, or sexual)	☐	☐
Prior suicide attempt	☐	☐
Fascination with death and violence	☐	☐
History of bullying or interpersonal violence	☐	☐
Confusion or conflict about sexual orientation/identity	☐	☐
Compulsive, extreme perfectionism	☐	☐

Family Risk Factors	Yes	No
Family History of suicide	☐	☐
Depressed and/or suicidal parents	☐	☐
Alcoholic and/or drug addicted parents	☐	☐
Changes in family structure (e.g. death, divorce, remarriage, frequent Moves/relocation)	☐	☐
Financial Difficulties	☐	☐

Community Risk Factors	Yes	No
Access to lethal means (e.g. firearms or other lethal means)	☐	☐
Stigma associated with help-seeking	☐	☐
Lack of access to helping services	☐	☐
Loss of family, friends, or idols to suicide	☐	☐
Anniversary of someone else's suicide or other death	☐	☐
Incarceration or loss of freedom; trouble with the law	☐	☐

j. List all current medications and dosage. List below, for what problem, and how well they work.

Name	Dose	Reason	How Long	Effectiveness

_____

_____

_____

k. List all past medications,for what problem, and how well they work.

Name	Dose	Reason	How Long	Effectiveness

_____

_____

7. Unusual Experiences or Crises

a. Deaths in the family or of friends or pets. How did child react? How old was child?

_____

_____

What was parental response to this crisis? _____

b. Other frightening events? If so, please describe event and child's response and age:

_____

_____

c. Have there ever been periods when your child seemed to stop developing or returned to more immature behavior? ____ yes ____ no If yes, describe situation and age: _____

_____

8. Education and Employment

a. List schools attended from preschool to the present. Note any problems experienced:

_____

_____

_____

_____

Child's Name

b. Has your child been evaluated by a school psychologist or ever had an IEPC?

yes ____ no ____ If so, list date(s): _____

c. Problems with reading and/or writing? If yes, explain_____

d. Have there been problems relating with teachers? yes ____ no ____ If yes, describe:
_____

_____

e. Name and phone number of current teacher: _____

f. Name and phone number of current school counselor or social worker: _____

_____

g. Have there been problems relating with other children? yes ____ no ____ If yes, describe:
_____

_____

h. Has your child worked outside the home? _____

i. What are your child's responsibilities at home (chores, etc.)? _____

_____

9. Relationships with Family and Community

a. How does your child relate with each parent? _____

_____

b. Which parent does this child most resemble in terms of disposition: _____

Looks: _____ Attitude toward others: _____

c. How does father discipline this child? _____

d. How does mother discipline this child? _____

e. Which parent is most upset by this child's behavior? _____

f. Do any other adults outside of school spend regular time with this child? yes ____ no ____

If yes, who? _____

g. Describe relationship with brothers and sisters: _____

_____

h. Describe child's best friends (first names, ages, etc.) _____

_____

i. Any contacts with police or Protective Service? ____ yes ____ no If yes, describe:

_____

j. How often has family moved? _____

k. In what groups does child participate? _____

l. Any religious participation? _____

m. How does child feel about therapy? _____

10. Family Background

Mother (or primary female caretaker, i.e. stepmother, grandmother, etc.):

a. Where did you grow up? _____

b. Ethnic, cultural, and religious background: _____

_____

c. Names/ages of your brothers and sisters: _____

d. How did you get along with your parents and siblings as a child? How are these relationships now?

_____

_____

e. How much contact do you and your child have with your side of the family? _____

_____

Father (or primary male caretaker, i.e. stepfather, grandfather, etc.):

a. Where did you grow up? _____

b. Ethnic, cultural, and religious background: _____

_____

c. Names/ages of your brothers and sisters: _____

d. How did you get along with your parents and siblings as a child? How are these relationships now?
_____

_____

e. How much contact do you and your child have with your side of the family? _____

_____

11. Substance Use (only applicable if age 12 or over)

Please check all that apply:

a. Nicotine ☐ b. Alcohol ☐ c. Prescription medication ☐ d. Illicit drugs ☐

e. Over-the-counter medications ☐ f. None of the above ☐

Please describe any checked items:

_____

12. In your own words, what do you see as your child's personal strengths, needs, including assistive technology and advanced directives, abilities and/or interests and preferences?

_____

_____

_____

13. Please list three main changes with your child's feelings or behavior that you hope to see with the assistance of therapy.

(1) _____ (2) _____ (3) _____

14. Complimentary health approaches What else has your child tried before to help themselves reduce their problems/concerns?

_____

_____

_____

Child's Name

15. **Resources and involvement of client and others**:_____

_____

16. **Possible referrals to other community services:**_____

17. **Transition/Discharge Plan:**

    a. Criteria (client-specific behaviors:_____

    _____

    b. Estimated date of discharge (M/Y): _____

    c. Aftercare plan:

    _____

_____ _____ _____ _____

Signature of Client or Parent Date Signature of Therapist Date

Revised: 5/19 cp

_____

Child's Name