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Licensed Marriage & Family Therapist
Professional Corporation

Child Questionnaire

Child's Name _____ Date _____
Child's Address _____
City & Zip _____
Child's Home Phone _____
Child's Age _____ Date of Birth _____ Ethnicity _____
Social Security Number _____
Child's School _____ Grade ____ Teacher _____

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What is your current concern(s) about your child? _____
_____
_____

When did the problem(s) start? _____

Were there any family or lifestyle changes that occurred at the time the problem(s) started? _____
_____

What have you done to address the problem(s) (i.e., medical treatment, other therapy, etc.)? _____
_____

Has your child received previous therapy Y/N

Name(s)	Address	Date of Service
_____	_____	_____
_____	_____	_____

Has your child been hospitalized for psychological reasons Y/N

Hospital(s)	Address	Date of Hospitalization
_____	_____	_____
_____	_____	_____

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Family Structure:
Mother/Stepmother _____ Age ____ Occupation _____
Contact Phone _____
Father/Stepfather _____ Age ____ Occupation _____
Contact Phone _____

Name(s) of birth parents (if different from above)
Mother _____ Age ____ Occupation _____
Father _____ Age ____ Occupation _____

Monthly Household Income $_____ # in Household _____

Siblings (Name and Age)

_____ _____
_____ _____

Others living in the home _____

Family History – Please check if any of the following apply

	Child	Mother	Father	Sibling	Grandparent
Depression	____	____	____	____	____
Suicide Attempts	____	____	____	____	____
Alcohol Use/Abuse	____	____	____	____	____
Drug Use/Abuse	____	____	____	____	____
Mental Problems	____	____	____	____	____

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Symptoms - Please indicate any symptom or behavior that applies to your child, note a 1 for mild, 2 for moderate and 3 for severe

___ nail biting	___ anger	___ plays with matches or fire
___ bedwetting	___ irritability	___ hurts animals
___ soils underwear	___ shyness	___ disobeys rules
___ specific fears	___ academic issues	___ speech problems
___ anxiety/nervous	___ behavior issues/home	___ suicidal thoughts
___ sadness	___ behavior issues/school	___ suicidal attempts
___ depression	___ truancy	___ medical problems
___ poor concentration	___ peer problems	___ sleeping problems
___ attention problems	___ adult relation issues	___ poor appetite
___ difficulty w/directions	___ disrespects authority	___ physical abuse
___ mood swings	___ lying	___ sexual abuse

___ negativism ___ stealing ___ alcohol use/abuse
___ temper tantrums ___ destroys property ___ drug use/abuse
___ gang involvement ___ cigarette use ___ other _____

Please list any other information that would help us to understand your child
_____
_____

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Medical History – If your child's medical history includes any of the following, note child's age when the incident or illness occurred and any other helpful information.

___ Yes ___ No Childhood diseases _____
___ Yes ___ No Operations _____
___ Yes ___ No Hospitalizations for illnesses _____
___ Yes ___ No Head Injury ____ with ___ without unconsciousness
___ Yes ___ No Convulsions ____ with ___ without fever
___ Yes ___ No Meningitis or encephalitis _____
___ Yes ___ No Immunization reactions _____
___ Yes ___ No Persistent high fevers _____
___ Yes ___ No Eye problems _____
___ Yes ___ No Ear problems _____

Overall rating of your child's health –
___ healthy ___ normal ___ unhealthy

Name & address of physician _____
Date of last physical exam _____
Any current illness(es) be treated _____
Any medications being taken _____

Pregnancy – were there any complications during the pregnancy? Y/N Explain:
_____
Delivery – any complications during delivery? Y/N Explain:
_____

Peer Relationships

___ Yes ___ No Does your child want to be friends with others?

___ Yes ___ No Do others want to be friends with your child?

___ Yes ___ No Are your child's friends about the same age as your child?

If no ___ younger ___ older

___ Yes ___ No Does your child prefer to play with others?

Describe any problem(s) your child may have with peers _____

_____

School

Has your child ever had to repeat a grade? Y/N

Present class placement ___ advanced ___ regular ___ special

Rate your child's school experiences related to academic learning

	Good	Average	Poor
Nursery School	___	___	___
Kindergarten	___	___	___
Current Grade	___	___	___

Rate your child's school experiences related to behavior

	Good	Average	Poor
Nursery School	___	___	___
Kindergarten	___	___	___
Current Grade	___	___	___

Does your child's teacher see any of the following as problems in the classroom?

___ doesn't sit still ___ doesn't cooperate in group activities

___ wanders around the room ___ best one-on-one

___ shouts out ___ doesn't listen

___ doesn't wait for turn ___ other _____

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What is your child's best attribute? _____

_____

What do you hope for your child now? _____

_____

What do you hope for your child in the future? _____

_____

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Completed by:

_____ _____ _____

Signature Relationship Date