DREAMLIFE PSYCHOLOGICAL SERVICES

NEW CLIENT QUESTIONNAIRE – CHILD/ADOLESCENT
**** Please use black ink to complete**

Please complete this form the best you can about your child. The information you share will help me gain an understanding of your concerns.

Today's Date: _______________

Child's Name: ______________________________________ **Gender:**__________________________

Date of Birth:__________________**Age:** ____ **Racial/Ethnic Background**: ____________________________

Grade in School: _____**School Attending:** ____

Form Completed By: _______________________________ **Relation to Child**:_________________________

REASON FOR REFERRAL:

Who referred you for services?

What has happened/is going on that caused you to seek services? What is the main issue concern?

What other help have you sought recently?

LIVING SITUATION:

PARENTS:

	Name	Age	Occupation
Parent			
Parent			
Step-Parent			
Step-Parent			

Parents Marital Status: Married Widowed Divorced Single Partnered

Who has legal custody? ____

If shared physical custody, what is the arrangement: ____

Others living in the house with your child

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Name	Age	Relationship	Occupation/Grade	Quality of Relationship

Pets: ____

PROBLEMS AND CONCERNS:
What major stresses or changes have occurred in your child's life in the past 2 years? (moves, school, job change, divorce, deaths,
etc.)____
____

How would you estimate your child's **current level of life stress**?
_____Low
_____Medium
_____High
_____Manageable
_____Difficult to manage

In general, have your child's symptoms been
_____ Staying about the same
_____ Getting worse
_____ Coming and going (intermittent)
_____ Other: ____

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Sleep

Check all that apply		Describe	Frequency	How long has it been happening?
	Problems falling asleep			
	Problems staying asleep			
	Nightmares			
	Difficulty getting up			
	Other			

How many hours of sleep does your child typically get a night? ____

What time is their bedtime during the week?________________ When do they usually get up?________________

Is it different on weekends? No ______ Yes ______ If yes, how so?___________________________________

Daytime napping? ___No ____Yes Length of nap:__________

Eating

Check all that apply		Describe	Frequency	How long has it been happening?
	Eating concerns			
	Made comments about needing to lose weight or being fat			
	Purges			
	Is dieting			
	Appetite changes			
	Weight changes			
	Hoards/Hides/Sneaks food			
	Other			

Mood

Check all that apply		Describe	Frequency	How long has it been happening?
	Lacks interest in activities they use to enjoy			
	Changed level of activity			
	Changed groups of friends			

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	Socially withdrawn			
	Fatigue			
	Tearfulness/Cries easily			
	Sadness			
	Depression			
	Morbid Thoughts (talking about death)			
	Suicidal Threats			
	Suicidal Intent/Plans			
	Self-Harming Behavior (cutting, erasing self, punching walls, etc)			
	Mood swings/emotional lability (fine one minute, mad/sad the next)			
	Easily Irritated			
	Other			

Behavior and Attention

Check all that apply		Describe	Frequency	How long has it been happening?
	Concentration Problems			
	Having too much energy/cannot sit still			
	Focus too much (in their own world)			
	Completes tasks carelessly			
	Doesn't notice when they make mistakes			
	Distracts/Annoys others			
	Bullies others			
	Is bullied			
	Disorganized/Forgetful			

	Has difficulty following directions (school, home, in public)			
	Aggressive behavior			
	Lies/omits information/does not tell the truth			
	Takes things that do not belong to them			
	Running away			
	Impulse control			
	Mean to animals			
	Gets stuck or perseverates on certain things			
	Poor judgment about safety			
	Plays with fire/matches			
	Destroys own/others' possessions			
	Other			

Anxiety

Check all that apply		Describe	Frequency	How long has it been happening?
	Worry/Anxiety			
	Fearfulness			
	Excessive shyness			
	Social Fear			
	Withdrawn			
	Unassertive			
	Stomach aches/headaches/pain			
	Flashbacks/intrusive thoughts			
	School Refusal			
	Hypervigilance			
	Startles Easily			
	Compulsive Behavior			
	Other			

Other Symptoms

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Check all that apply		**Describe**	**Frequency**	**How long has it been happening?**
	Personality Change			
	Peer/social Problems			
	Seeing, feeling, tasting, smelling or hearing things that are not there			
	Unusual/bizarre ideas			
	Hygiene problems			
	Other			

Any other symptoms or issues that you think would be helpful for us to know about?

CHILDHOOD LIFE EVENTS:

Below is a list of events that may occur in a child's life. Please check any events that you know or suspect your child to have experienced.

X if Yes	Age	Event	Other Information
		Major Natural Disaster (flood, tornado)	
		House Fire	
		Serious Car Accident	
		Physical Abuse	
		Witnessed Others Being Physically Abused	
		Periods of Time When Adults were Unable to Care for them	
		Emotional abuse	
		Impaired Parenting (due to parental mental health issues, substance use, etc)	
		Exposure to Domestic Violence	
		Exposure to Adult Substance Use	
		Multiple Separations from Caregiver (military deployments, working away from home)	
		Frequent Moves	
		Homelessness	
		Sexual Abuse	
		Exposure to Sexual Material	
		Sexual Harassment	
		Bullying	
		Unexpected Death of a Close Relative	
		Major Medical Procedure or Surgeries	

		Any Other Scary or Dangerous Event	
		Other traumatic events	

SUBSTANCE USE HISTORY:

No Yes

___ _____ To your knowledge, does your child drink?

If yes, when did they start and how often do they drink?

____

_____ _____ To your knowledge, does your child smoke cigarettes?

If yes, when did they start and how often do they smoke?

____

___ _____ To your knowledge, does your child use drugs?

What have they used? ____

When did they start and how often do they use?_________________________________

___ _____ Has your child ever attended chemical dependency treatment?

Where: _______________________________ When:___________________________________

CAGE

Yes	No		Describe
		Has your child used more than one chemical at a time to get high?	
		Does your child attempt to avoid family activities to use?	
		Does your child have a group of friends that drink or use?	
		Does your child use substances to cope with feelings such as depression or sadness?	

If your child has used substances, what *Negative Consequences* have they experienced related to their use?

How much time does your child spend using electronic media?

Does your child engage in any other behavior in an addictive way (computer gaming, shopping, etc)

STRENGTHS & INTERESTS:

Describe your child's strengths:

Describe your child's interests:

MENTAL HEALTH HISTORY:

MENTAL HEALTH CARE HISTORY:
Does your child see any other mental health care provider now? ___No ____Yes (explain)

Has your child had **previous** mental health services? If so, when? By whom?
Psychiatric care____
Psychotherapy ____
Mental health hospitalization____________________________________
Partial hospitalization program___________________________________
Psychological testing____
Chemical dependency treatment_________________________________
CTSS services____
Children's Mental Health Case Manager____
Other: ____

Has your child been diagnosed with a mental illness/mental health problem?
_____No
_____Yes (list)____

Current medicines for mental health problems: (name and dosage)

Has your child taken mental health medicines in the **past**?
_____No
_____Yes: Name of medication Helpful/negative effects

Name of medication	Helpful/negative effects
__________________________	_____________________________________
__________________________	_____________________________________
__________________________	_____________________________________
__________________________	_____________________________________
__________________________	_____________________________________

MEDICAL HISTORY:

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Primary Care Physician: ____ Location:________________________

Date of Last Well Child Visit: ____

Date of Last Dental Visit: ____

If your child is female, age of onset of menstruation?_______

Current medical conditions/problems ____

Has your child had any prior surgeries? ____No ____Yes (what and when)

Has your child any been hospitalized for any reason? ____No ____ Yes (for what and when)

Current Medications (dosage): ____

Past Medications: ____

Allergies: ____

Concussion/Loss of consciousness/Seizure:___No____Yes(explain)__________________________________

FAMILY STRUCTURE:
Your child's birth order:________________
# of sisters and ages:____________________________
# of brothers and ages:__________________________

Do any siblings reside out of the home ___No____Yes

Who are the other important people in your child's life?(i.e. relatives, mentors, coaches, family friends, etc)

How does your child get along with your extended family or adult friends?

DEVELOPMENTAL HISTORY:
Where was your child born?____

Did you give birth to or adopt your child?___________________________

If you adopted your child answer these questions:

Child's age at adoption:_______

Briefly describe circumstances of adoption:

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Answer these questions **only** if you gave birth to your child:

What was your reaction to finding out that you were pregnant with your child?

What was your relationship status when you found out you were pregnant?

What was the pregnancy with your child like?

Was your child exposed to any substances during pregnancy or prior to learning of pregnant?
______drugs (prescribed or street drugs),
______tobacco, or
_____ alcohol during pregnancy?

Did you have any medical issues or sources of extreme stress during pregnancy?

Describe the delivery:
_____Vaginal
_____C-section
_____Uncomplicated
_____Premature (how early?) ______________________________
_____Postmature_______________________________________
_____Complicated (describe) ____
____

Did you or the child stay in the hospital for an extended period of time?
_____Yes
_____No (describe) ____

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Describe any challenges during infancy (i.e. maternal depression, financial stress, frequent moves).

Describe what your child was like to care for as an infant (i.e. easy, difficult, enjoyable, colicky, fussy)

Milestone	Age	Other information
Distress when separating from caregivers		
Crawl		
Walk		
Potty Trained—dry during day		
Dry at night		
First Sentence		
Slept through night		
Ate solid food		

Where has your child lived?	Age of Move	Reason for Move
Born:		

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FAMILY HISTORY:

Are there any relatives of the child (including parents, grandparents, aunts, uncles or cousins who have any of the following conditions?

	Relationship		**Relationship**
ADHD		Autism/Asperger's	
Alcohol or Drug Problems		Anxiety/OCD	
Brain Damage		Bipolar Disorder/ Manic Depression	
Chronic Pain		Convulsions/Seizures	
Depression		Developmental Delays	
Domestic Violence		Eating Disorder	
Learning Disorders		Mental Health Hospitalizations	
Nerve Problems		Personality Disorder	
Physical Abuse		PTSD	
Schizophrenia		School Problems	
Sexual Abuse		Suicide Attempts	
Tic or Tourette's Disorder		Other	

EDUCATIONAL HISTORY:
SCHOOLS ATTENDED

	School	What was your child's experience?	Typical Grades	Other Comments	Suspension/ Detention
Preschool					
Kindergarten					
1st to 3rd grade					
4th to 5th grade					
6th to 8th grade					

9th to 12th grade					

Does your child have learning, social or behavior problems at school?
_____No
_____Yes (describe)
Does/has your child receive any special educational services (IEP, 504, Title 1) or have special educational needs?
_____No
_____Yes (describe)

SOCIAL HISTORY:
Does your child have a positive group of friends?

Is your child dating?

Is your child sexually active?

Is your child/has your child been employed? Y N If Yes, where: ____________________________________

Has your child ever had any prior social service involvement?
_____No
_____Yes (when) _________(social worker's name) ____

Has the child been in foster placement?
_____ No
_____ Yes (when and why)____
____

LEGAL HISTORY:

Has your child ever been in trouble with the law? ___no ____Yes
If yes, when and what for?____
Is there a current probation agent?____

CULTURAL ISSUES:
Does your family participate in any faith, religious or spiritual practices?
___No
___if Yes, Describe: ____

Are there other cultural issues that you would like to share?

How would you describe your family's socio-economic status?

Is there any other information that you think is important for us to know about your child or particular concerns that you have?

Thank you for taking the time to complete this questionnaire.