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CHILD HISTORY QUESTIONNAIRE

Name: _____ **Grade:** _____

Age: _____ **School:** _____

Person Completing Form: _____

Family History

Parents

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

Date of Divorce:_____

If divorced, who has legal custody? _____

_____

_____

Were the child's parents ever married? ___ Yes ___ No

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? _____ Yes ___ No If Yes, describe:

_____

_____

Client's Mother

Name: _____ Age: _____Occupation: _____Hours worked per week _____

Where employed: _____

Mother's education: _____

Is the child currently living with mother? ___ Yes _____ No

___Natural parent ___Step-parent ___Adoptive parent ___Foster home ___ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the mother?__ Yes __ No If Yes, please explain:

_____

_____

Client's Father

Name: _____ Age: _____ Occupation: _____Hours worked per week: _____

Where employed: _____

Father's education: _____

Is the child currently living with father? __ Yes ___ No

___Natural parent ___Step-parent ___Adoptive parent ___Foster home ___Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the father? __Yes __No

If Yes, please explain:

_____

_____

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
_____	___	___ F ___ M	___ home ___ away	___ poor ___ average ___ good
_____	___	___ F ___ M	___ home ___ away	___ poor ___ average ___ good
_____	___	___ F ___ M	___ home ___ away	___ poor ___ average ___ good
_____	___	___ F ___ M	___ home ___ away	___ poor ___ average ___ good
Others living in the household			Relationship (e.g., cousin, foster child)	
_____	___	___ F ___ M	_____	___ poor ___ average ___ good
_____	___	___ F ___ M	_____	___ poor ___ average ___ good

Has the child experienced any physical abuse sexual abuse or neglect? ___Yes ___No

If Yes, describe: _____

_____

_____

Has the child/adolescent experienced death? (friends, family pets, other) ___ Yes ___ No

At what age? _____ If Yes, describe the child's/adolescent's reaction: _____

_____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

__ Yes ___ No If Yes, describe: _____

_____

Developmental History

Pregnancy/Birth

Has the child's mother had any occurrences of miscarriages or stillborns? ___Yes ___No

If Yes, describe: _____

Length of pregnancy: ___ Mother's age at child's birth: _____

Did the mother use drugs, cigarettes or alcohol? ___ Yes _____

No If Yes, type/amount: __

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication) __Yes __No

If Yes, describe: _____

Length of labor: _____ Induced: ___ Yes ___ No Caesarean? ___ Yes ___ No

Baby's birth weight: _____ Baby's birth length: _____

Describe any physical or emotional complications with the delivery: _____

_____

Describe any complications for the mother or the baby after the birth: _____

_____

Length of hospitalization: Mother: _____ Baby: _____

Developmental History

Please note the age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____

Took 1st steps: _____ Tied shoe laces: _____

Spoke words: _____ Rode two-wheeled bike: _____

Spoke sentences: _____ Toilet trained: _____

Compared with others in the family, child's development was: __ slow ___ average ___ fast

Age for following developments (fill in where applicable)

Began puberty:___Menstruation: ___

Issues that affected child's development (e.g., inadequate nutrition, neglect, etc.)

_____

_____

Medical/Physical Health

Health Conditions

___Abortion ___Hayfever ___Pneumonia ___Asthma ___Heart trouble ___Polio ___Blackouts ___Hepatitis __Pregnancy
___Bronchitis ___Hives ___Rheumatic Fever ___Cerebral Palsy ___Influenza ___Scarlet Fever ___Chicken Pox ___Seizures
___Congenital problems ___Measles ___Severe colds ___Croup ___Meningitis ___ Concussions/Head injury ___Diabetes
___Diphtheria ___Multiple sclerosis ___Thyroid disorders ___Dizziness ___Mumps ___Vision problems ___Ear aches
___Wearing glasses ___Ear infections ___Nose bleeds ___Whooping cough ___Eczema ___Other skin rashes Fevers

List any current health concerns: _____

Current prescribed medications	Dose	Dates	Purpose	Side effects

Immunization record: Has the child received all immunizations? ___Yes ___No
Name of Physician:_____

Nutrition

Meal	How often	Typical foods eaten	Typical amount eaten
Breakfast	____ / week	_____	___ No __ Low ___ Med ___ High
Lunch	____ / week	_____	___ No __ Low ___ Med ___ High
Dinner	____ / week	_____	___ No __ Low ___ Med ___ High
Snacks	____ / week	_____	___ No __ Low ___ Med ___ High

Comments: _____
Describe any concerns regarding your child's weight or eating habits: _____
_____

Education

Current school: _____
Type of school: ___Public ___Private ___Home schooled ___Other (specify):_____
Grade: _____ Teacher: _____
In special education? ____ Yes __ No If Yes, describe: _____
In gifted program? ___ Yes ____ No If Yes, describe: _____
Has child ever been held back in school? ___ Yes ___ No If Yes, describe: _____
Which subjects does the child enjoy in school? _____
Which subjects does the child dislike in school? _____
What grades does the child usually receive in school? _____
Have there been any recent changes in the child's grades? __ Yes ___ No
If Yes, describe: _____
Has the child been tested psychologically? ___ Yes ___ No Describe:_____
Check the descriptions which specifically relate to your child.

Feelings about School Work:

___Anxious ___Passive ___Enthusiastic ___Fearful ___Eager ___No expression ___Bored ___Rebellious

___ Other (describe): _____

Approach to School Work:

___Organized ___Industrious ___Responsible ___Interested ___Self-directed ___No initiative ___Refuses

___Does only what is expected ___Sloppy ___Disorganized ___Cooperative ___Doesn't complete assignments

___ Other (describe): _____

Performance in School (Parent's Opinion):

___ Satisfactory ___Underachiever ___Overachiever ___Other (describe):_____

Child's Peer Relationships:

___ Spontaneous ___Follower ___Leader ___Difficulty making friends ___Makes friends easily ___Long-time friends
Shares easily ___Other (describe): _____

If the child is involved in a vocational program or works a job? Describe: _____

Are there any problems?_____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, physical fitness, sports, church activities etc.)

_____

_____

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? ___Yes ___ No

If Yes, describe: _____

_____

Counseling/Prior Treatment History

	Yes	No	When	Where	Overall experience
Counseling	____	____	_____	_____	_____
Psychiatric	____	____	_____	_____	_____
Drug/alcohol treatment	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____
Psych. Testing	____	____	_____	_____	_____

Additional Comments:_____

_____

_____

Legal History

Has your child ever been involved in the legal system? ___Yes ___No

If Yes, describe: _____

Is your child currently involved in the legal system? ___Yes ___No

If Yes, describe: _____

Other

Please describe any other concerns you have regarding your child/adolescent:

_____

_____

_____

_____