

New Day Counseling, Troy, MI 48084

CHILD/ADOLESCENT LIFE HISTORY Questionnaire

The purpose of this questionnaire is to obtain a comprehensive understanding of your child—his/her life experience and background. In answering the following questions as accurately and completely as you can, you will facilitate in the development of a treatment plan that is best suited to your child’s individual needs. If you would rather not answer a question, simply leave it blank or write, “do not want to answer.” Use N/A where **not applicable**.

DATE: _____

CHILD’S NAME: _____

SEX: (M) _____ (F) _____ **AGE:** _____

DATE of BIRTH: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

Name of person completing form (please print): _____

Relationship to child: _____

In case of emergency, contact

Name: _____ Relationship: _____

Phone(home) _____ (work) _____ (other) _____

Address (street, city, state, zipcode) _____

Presenting Problems: (check or circle all that apply)

- | | | |
|----------------------|----------------------------|--------------------|
| Sad, very unhappy | Moody | Angry, defiant |
| Cries frequently | Acts without thinking | Stealing |
| Irritable | Stubborn | Lying |
| Temper tantrums | Disobedient | Sexual acting out |
| Withdrawn, loner | Infantile | School performance |
| Daydreaming | Mean to others, bullies | Truancy |
| Fearful | Destructive | Bed wetting |
| Worries | Trouble with the law | Soiled pants |
| Clumsy | Running away | Eating problems |
| Overactive | Self-mutilating | Overweight |
| Slow | Head banging | Stomachaches |
| Short attention span | Rocking | Sleeping problems |
| Distractible | Shy | Nightmares |
| Lacks initiative | Avoids adults | Often ill |
| Lazy | Strange, unusual thoughts | Drug use |
| Undependable | Strange, unusual behaviors | Alcohol use |
| Peer conflict | Tics or twitches | Fire setting |
| Phobic | Eye blinking, jerking | Suicide talk |

Are there any other problems not listed above? _____

How long have these problems occurred? (number of weeks, months, years)

Problems perceived to be: ___very serious ___serious ___somewhat serious ___not serious

What are your expectations of your child? _____

What changes would you like to see in your child? _____

Current Family Situation:

MOTHER—Relationship to child ___natural parent ___relative
___step-parent ___adoptive parent

Occupation _____ Education _____

Birthplace _____ Age _____

FATHER—Relationship to child ___natural parent ___relative
___step-parent ___adoptive parent

Occupation _____ Education _____

Birthplace _____ Age _____

Marital History of Parents:

Natural Parents: ___ married when _____ ages _____
 ___ separated when _____
 ___ divorced when _____
 ___ deceased M or F _____

Step Parents: ___ married when _____

If child is adopted: Reason and circumstance _____
 Age when child first in home _____
 Date of legal adoption _____
 Does child know of adoption? _____

Living Arrangements:

	Places	Dates
Number of <u>moves</u> in child's life _____	_____	_____
	_____	_____
	_____	_____

Present home: ___ condo ___ house ___ apartment ___ other: _____

Does the child share a room with anyone else? ___ Yes ___ No *If yes, with whom?* _____

If no, how long has he/she had own room? _____

Was the child ever placed, boarded, or lived away from the family? ___ Yes ___ No Explain: _____

Has either parent ever been separated from the child (i.e. long hospitalization, marital separation, divorce, etc.)? ___ Yes ___ No Explain: _____

_____ Age of child at time of separation _____

BROTHERS and SISTERS: (indicate if step-brothers or step-sisters)

Name	Age	Sex	School or Occupation	Present Grade	Living at home (yes or no)	Use drugs or alcohol (yes or no)	Treated for drug abuse (yes or no)
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Others living in the home (and their relationship to child):

Does or did any member of the child's family have any problems with:

reading spelling math speech depression anxiety
 self-destructive behavior schizophrenia attempted or committed suicide

If yes, please explain: _____

Any major family changes (losses, illnesses, deaths, births, etc.)? _____

Age of child at time of change _____

Developmental History

Prenatal—Was child wanted? Yes No Planned for? Yes No

Paternal support and acceptance (explain): _____

Normal pregnancy? Yes No

If mother was ill or upset during pregnancy, explain: _____

Check any that were used during pregnancy: Tobacco Alcohol Drugs

Birth: Full term Premature

Length of labor: _____ hours/mins.

Type of delivery: Normal Breech Cesarean Other: _____

Condition of child at birth: _____

Was it necessary to give the infant oxygen? Yes No

At what age did your child: Walk alone Spoke single words Sentences

At what age was your child toilet trained? _____ Was this difficult? Yes No

Has your child ever experienced injuries, illnesses, or hospitalizations apart from the normal childhood illnesses? Yes No Please describe (including age at time of experience):

Is your child currently taking any medications? Yes No If yes, please explain:

<u>Name of Medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Reason</u>
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Has your child ever talked about or attempted suicide? ___ Yes ___ No Explain: _____

Is there history of sexual abuse or physical abuse? ___ Yes ___ No ___ Not sure

If yes, what age? _____

Do you have knowledge or think your child is using drugs, alcohol, and/or cigarettes?

___ Yes ___ No Explain: _____

Primary Care Physician (Name, Address, Phone Number): _____

FOR GIRLS:

Menstrual period: Age of first period _____ Problems: _____

Pregnancies: ___ Yes ___ No

Terminated Pregnancies: ___ Yes ___ No *If yes, how many* _____

Education

	Name of School	City/State	Dates Attended:		Grades completed at this school
			From	To	
Preschool	_____	_____	_____	_____	_____
Elementary	_____	_____	_____	_____	_____
Middle school	_____	_____	_____	_____	_____
High school	_____	_____	_____	_____	_____

Types of classes: ___ regular ___ learning disability ___ continuation
___ emotionally handicapped ___ other: _____

What grade is he/she in? _____ How much does he/she like school? _____

Did child skip a grade? ___ Yes ___ No Repeat a grade? ___ Yes ___ No

If yes, what grade(s)? _____

Please describe any difficulties your child is experiencing in school, or has experienced in the past _____

Has your child had special testing in school? (*If yes, what were the results?* _____)

Psychological ___ Yes ___ No *Vocational* ___ Yes ___ No *Special Ed* ___ Yes ___ No

Has your child ever received psychiatric or counseling services? ___ Yes ___ No

If yes, please explain: _____

ACADEMIC PERFORMANCE:

Highest grade on last report card and subject/class? _____

Lowest grade on last report card and subject/class? _____

Favorite subject? _____

Least favorite subject? _____

Does child participate in extracurricular activities? ___ Yes ___ No

Explain: _____

List child's special interests, hobbies, skills: _____

What are child's educational aspirations? ___ quit school
___ graduate from high school
___ go to college
___ other: _____

Social Development:

Relationship to siblings and peers: ___ individual play ___ group play ___ competitive
(check all that apply) ___ cooperative ___ leader ___ follower

How many friends does child have? ___ a lot ___ a few ___ none

Describe special habits, fears, or idiosyncrasies of the child: _____

Has the child ever had difficulty with the police? ___ Yes ___ No (*If yes, explain*) _____

Has child ever appeared in juvenile court? ___ Yes ___ No (*If yes, explain*) _____

Has the child ever been on probation? ___ Yes ___ No
From To Reason Probation Officer

Has child ever been employed? ___ Yes ___ No
Job Employer How long

ADDITIONAL COMMENTS—Please include any additional information that you feel would be helpful in the understanding of your child’s situation.

Signature of person completing form _____ **Date** _____