STUDIO FOR CHANGE

CHILD INITIAL QUESTIONNAIRE

Client Information:

Client Name: _____ Nickname or Preferred Name: _____

Age: _____ Date of Birth: _____ Languages Spoken: _____

Gender: _____ Ethnic / Cultural Background: _____

Address: _____

Religious / Spiritual Practice: _____

Parent Information:

(1) Parent Name: _____ Occupation: _____

Age: _____ Gender: _____ Languages Spoken: _____

Cell Phone: _____ Work Phone: _____

Email: _____ Ethnic / Cultural Background: _____

Address (if different from client): _____

(2) Parent Name: _____ Occupation: _____

Age: _____ Gender: _____ Languages Spoken: _____

Cell Phone: _____ Work Phone: _____

Email: _____ Ethnic / Cultural Background: _____

Address (if different from client): _____

Relationship Status: _____

Current custody arrangement (if applicable): _____

_____

Step – parent information (if applicable – name, cell phone, age, occupation): _____

_____

_____

Additional Family Members and Other People Living in the Home:

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Payment:

Person responsible for payment: _____

Signature of person responsible for payment: _____

Appointment Reminder:

If you would like an automated appointment reminder one day before each appointment, please provide your cell number if you'd like a text and / or your e-mail address if you'd like an e-mail:

Cell phone number: _____ E-mail address: _____

Referred By:

How did you learn about (BUSINESS NAME)? _____

If you found us on the internet, what site were you on? _____

In Case of Emergency, Please Call:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Presenting Problem:

1. Please share your current concerns that brought you to therapy; specify the nature of the problem, duration, frequency, and severity: _____

_____

_____

_____

_____

_____

2. What have you tried so far to address your child's concerns? _____

_____

_____

3. How do you hope I can be of help? _____

_____

_____

4. What do you think is a realistic time frame for solving your problem? _____

_____

_____

Goals and Strengths:

1. What are your goals for therapy? _____

_____

_____

2. What are your child's strengths? _____

_____

_____

3. What are your child's interests? _____

_____

_____

4. What are your family's strengths? _____

_____

_____

Client's Health:

Physician Name and Number: _____ Date of Last Visit: _____

Psychiatrist Name and Number: _____ Date of Last Visit: _____

1. Starting with birth and proceeding up to the present, list all allergies, diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had: _____

_____

_____

_____

_____

2. Has your child ever had any previous psychotherapy? If so, when, with whom, how long, and did you feel it was helpful? _____

_____

_____

Prescribed Medications	Purpose	Dose	Side Effects

Client Symptoms and Behaviors:

Please indicate how each of the following symptoms/problems/complaints are affecting your child. **Mark (1) for little affect, (2) for moderate affect, (3) for great affect.** Leave blank if it does not apply. Feel free to add comments as desired.

Accident-prone	Aggression towards others
Angry outbursts	Appetite increase/decrease
Argues/talks back	Binging/purging
Bossy to others	Breaks the law
Bullied by others	Bullies/intimidates
Cheats	Complains often
Cries easily	Cruel to animals
Destructive	Developmental delays
Difficulties with parent's relationship/new marriage	Difficulty concentrating
Disobedient/defiant	Fatigue/decrease in energy
Fearful/worries	Feelings are easily hurt
Fighting	Fire setting/plays with fire
Frequent stomachaches/headaches	Generalized anxiety
Hopelessness	Hearing voices
Hyperactive	Immature
Inappropriate sexual behaviors	Inattentive/distractible
Irritable	Isolates/withdraws
Lacks organization	Lacks respect for authority
Learning disability	Lethargic
Low frustration tolerance	Lying
Manipulates	Moody
Mute/refuses to speak	Nail biting/hair chewing
Need for high degree of supervision	Nervous
Nightmares	Oppositional
Overeats	Panic attacks
Poor sibling or friend relationships	Poor social skills
Problems falling/staying asleep	Procrastinates
Provokes others	Recent move/new school/loss of friends
Restless/fidgety	Rocking/repetitive movements
Runs away	Sad/unhappy
School avoidance	Sees things that aren't there
Self-harming behaviors/cutting	Separation anxiety
Sexual preoccupation	Shy/timid
Speech difficulties	Steals
Stubborn	Suicidal thoughts
Suicide attempt(s)	Swearing
Teased/picked on	Thumb sucking
Tics	Truancy
Weight change	Wetting/soiling bed/clothes

Child's School History:

Current School District: _____ Grade: _____

School Name: _____ Phone Number: _____

Review history of school functioning including strengths: (Gifted or accelerated learning program, learning/behavior problems, multiple school placements, past educational testing, estimated level of achievement): _____

_____

_____

Teacher/Counselor/IEP Coordinator: _____

Is child enrolled in special education? ☐ Yes ☐ No Is there a current IEP? ☐ Yes ☐ No (if yes, please provide a copy)

Child is designated: ☐ Emotionally Disturbed (ED) ☐ Specific Learning Disability (SLD) ☐ Other _____

Child's classroom is: ☐ Regular Education ☐ Regular Education with pull-out to Resource Room

☐ Special Day Class ☐ Inclusion in regular education (_____ hours/day) ☐Other _____

What school interventions have been used to address problems: ☐ None ☐ Special seating arrangement ☐ Tutoring

☐ Groups ☐ Classroom aide ☐Parent(s) called ☐ Other _____

Has the child been suspended/expelled in past 12 months? ☐ Yes ☐ No If yes, how many times and the reason? _____

_____

_____

Please check any of the following your family has experienced in the past year:

☐ Death of a family member or close friend
☐ Death of a spouse / partner
☐ Discrimination
☐ Divorce or separation
☐ Emotional, physical, or sexual abuse
☐ Family member left home
☐ Fired or laid off from a job
☐ Legal problems
☐ Major injury or illness
☐ Marriage / New partnership
☐ Moved
☐ New family member (through birth, adoption, or marriage)
☐ Retired from job
☐ Spouse / partner job loss or change
☐ Started or finished school
☐ Other: _____
_____

If you answered yes to any of these, please explain: _____

_____

_____

_____

Family History:

1. Describe any family history of physical or mental including depression or suicide: _____

2. Describe any family history of substance use or abuse: _____

3. Has anyone in your family ever experienced any emotional, physical, or sexual abuse? If so, who, what, for how long, and by whom? _____

4. Please describe significant events in your family life that may have had an impact on your child (i.e. major moves, changes in school, divorce, loss of a loved one, abuse and/or assault of any kind, legal troubles): _____

5. Is there anything else you would like me to know about you, your relationships, or your family? _____