Child/Adolescent Questionnaire

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Legal Name:

Preferred Name:

Age: Date of Birth: / /

Sex Assigned at Birth: M F Intersex

Gender: M F Other:

Pronouns: He/Him/His She/Her/Hers They/Their/Theirs Other:

Do you have a faith-based or spiritual practice?

Mother’s name:

Phone #: Email:

Street Address:

Mother’s name:

Phone #: Email:

Street Address:

Father’s name:

Phone #: Email:

Street Address:

Father’s name:

Phone #: Email:

Street Address:

Preferred point-of-contact:

Client resides with:

|  |  |  |
| --- | --- | --- |
| Name | Age | Relation to client |
|  |  |  |
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Parent’s marital status:

If divorced, please describe custody arrangement:

Can you supply legal documentation of this arrangement?

Presenting problem/reason for seeking treatment:

Besides therapy, how have you tried to manage this problem?

Previous Psychiatric Treatment: None Outpatient Inpatient

If applicable, please describe reason for treatment, clinic, dates of treatment, and outcomes:

Has your child ever been suicidal? Yes No

Has your child been hospitalized for suicidal ideation or suicidal attempt? Yes No

If yes, when and where?

When was the last time your child had a physical examination? Date:

Physician’s Name: Physician’s Phone #:

Psychiatrist’s Name: Psychiatrist’s Phone #:

Medical conditions:

Allergies:

Medications:

School environment:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Mainstream classroom |  | | Independent or home study | |  | Resource class | |  |
| IEP/504 plan |  | | Continuation school | |  | Speech/occupational | |  |
| Dislikes school |  | | Special Day class therapy | |  | Unmotivated | |  |
| Learning problems |  | | Tries, but does not do well | |  | Gifted program | |  |
| Repeated a grade |  | | Missed many school days | |  | Discipline referrals | |  |
| Suspensions, how many? | |  | | Expulsion, how many? | | |  | |

School name, grade, and most recent teacher:

What extracurricular activities is your child involved in?

What does your child enjoy?

How much “screen time” (TV, phone, computer, iPad) does your child have on a daily basis and what are they looking at (virtual classroom, social media, shows, news, YouTube, games)?

Do you eat meals together as a family? If so, how often?

What activities do you do together as a family?

How much sleep does your child get per night?

What do you like about your child?

Symptom Checklist

|  |  |  |  |
| --- | --- | --- | --- |
| Unresolved abuse/neglect issues |  | Weight loss/gain |  |
| Unresolved grief/loss |  | Binge eating |  |
| Excessive sadness |  | Not eating to lose weight |  |
| Loss of enjoyment of usual activities |  | Trying to lose weight by vomiting or exercising excessively |  |
| Irritability |  | Poor body image |  |
| Withdrawn, isolating |  | Hear voices |  |
| Feelings of emptiness |  | Seeing things that aren’t there |  |
| Low self-esteem |  | Disorientation |  |
| Tiredness, fatigue |  | Nightmares |  |
| Difficulty sleeping |  | Sleepwalking |  |
| Thoughts/attempts of suicide |  | Hair-pulling, picking at skin |  |
| Expressing a wish to die |  | Excessive physical pai |  |
| Poor concentration |  | Impulsivity |  |
| Excessive fears (phobias) |  | Difficulty finishing tasks |  |
| Panic, panic attacks |  | Difficulty paying attention |  |
| Nervousness |  | Excessive daydreaming |  |
| Repeating an act over and over that is unnecessary (e.g. washing counting) |  | Twitching or unusual movements |  |
| Overly concerned about germs, safety, or health |  | Running away |  |
| Excessive need for order, cleanliness |  | Sneaking out at night |  |
| Overly concerned with details |  | Stealing |  |
| Paranoia |  | Lying |  |
| Over-reactive |  | Abusive to animals |  |
| Temper outbursts |  | Recurring problems with the law |  |
| Argumentative |  | Destroying property |  |
| Defiant |  | Cigarette use |  |
| Swears/uses obscene language |  | Alcohol use |  |
| Blaming |  | Cannabis use |  |
| Violent impulses |  | Other drug use |  |
| Harmful to others |  | Bedwetting/daytime wetting |  |
| Periods of time with very high energy levels |  | Soiling in pants |  |
| Mood swings |  | Age-inappropriate interest in sex |  |
| Talking or thinking too fast |  | Questions/concerns about sexuality |  |
| Relationship problems |  | Participating in high-risk sexual activity |  |
| Overly sensitive to criticism |  | Questions/concerns about gender or gender expression |  |
| Difficulty trusting |  |

Please describe any notable mental health or behavioral issues of family/relatives:

What else do you want me to know about your child/you?

Parent/Guardian Signature: Date:

Parent/Guardian Signature: Date: