Client Questionnaire – (Child/Adolescent)

Date: _____

To be filled out by parent or client prior to the first session

The purpose of this questionnaire is to obtain a comprehensive picture of your background. In counseling, records are necessary to facilitate a more thorough understanding of one's issues. You are requested to answer these questions as fully and accurately as you can on this form in order to maximize your consulting time.

1. General Information

Client Name: _____ Age:___ Social Security# _____

Parent's Name (M) _____ (F) _____

Address: _____

_____

Telephone Number (Days): _____ (Evenings): _____

DOB: ___/___/___ Sex: _____ Grade: _____ School: _____

By whom were you referred? _____

Who is your medical doctor/Pediatrician? _____ Phone: _____

Notify in case of Emergency:

Name: _____ **Address:** _____ **Phone:** _____

Marital Status of Parents

☐ Never Married ☐ Divorced
☐ Married ☐ Separated
☐ Widowed ☐ Cohabitating

Race/Ethnic Origin (optional)

☐ White ☐ American Indian
☐ African American ☐ Asian
☐ Hispanic ☐ Bi-racial
☐ Other

Sex

☐ Male
☐ Female

Client's Present Living Arrangement

☐ Parents ☐ Friends ☐ Foster Care
☐ Guardian ☐ Other (please describe) _____

Custody (if client is child)

☐ Mother ☐ Father
☐ Joint ☐ Other ___

Immediate Family	Age	Sex	Relationship	Living in Household		Occupation/Grade
				Yes	No	
Client						

Parent's Military Service: Yes __No ____ Describe: _____

Parent's Employment Status (M) – Mother; (F) - Father

☐ Full-time (35 or more hrs/wk) ☐ Part-time (less than 35 hrs/wk) ☐ Retired
☐ Employed, not working due to extended illness ☐ Homemaker ☐ Unemployed
☐ Full-time student ☐ Seasonal Worker Other (please describe): _____

Occupation: _____

Parent's Education (M) – Mother; (F) - Father

High School/G.E.D. Yes _____ No _____ Special Training _____
Last grade completed _____ Highest Degree _____
Currently attending school/grade _____

Name: _____ Client ID _____

2. Description of Presenting Problem

State in your own words the nature of the problem that brought you to our office _____

_____

_____

_____

Please describe significant events (e.g. divorce, illness, adoption, trauma, etc.) which may relate to the development or maintenance of your problems: _____

_____

What previous solutions to your problems have been most helpful? _____

_____

Have you been in counseling before or received any prior professional assistance for your problems? If so, please name(s), professional title(s), dates of treatments and results:_____

_____

3. Special Issues

Regarding Your Child/Adolescent	**Yes**	**No**
Did they receive special educational assistance in school?	____	____
Were/are there any problems or concerns with performance or behavior at school/work	____	____
Were/are there any legal involvement or problems?	____	____
Are you as a family experiencing financial problems?	____	____
Do they have any problems or concerns related to sexuality or your sexual orientation?	____	____
Has any member of your family, immediate or extended, been treated for an emotional or substance abuse problems?	____	____
Are there any family members who may have had emotional or substance abuse problems who were not treated?	____	____
Are there any cultural concerns, spiritual beliefs or values of which we should be aware?	____	____

If yes, please describe: _____

_____

How much support do you get from your family, friends, church? (Please circle)

Great deal Some Little None

What community resources/self help groups are you currently utilizing? _____

4. Chemical Use History

Child/Adolescent Use:

Alcohol/Drug frequency/amount: _____

_____

	Current	**Past**
Do you believe your child/adolescent has a drug or substance Abuse problem?	☐ Yes ☐ No	☐ Yes ☐ No
Do you believe either parent has an alcohol or substance abuse problem?	☐ Yes ☐ No	☐ Yes ☐ No

Tobacco daily usage: C/A_____ Caffeine daily usage: C/A_____

What do you believe to be your child/adolescent's strengths? _____

_____

What do you believe to be your child/adolescent's weaknesses? _____

Additional Comments (Please include any other information you consider might be helpful to better understand the situation: _____

_____

5. Risk Assessment (of Your Child/Adolescent)

	YES	NO
Currently suicidal?	____	____
Ever been suicidal?	____	____
Ever have suicidal thoughts?	____	____
Previously attempted suicide?	____	____
Ever deliberately harmed themself in any way?	____	____
Have any thoughts about harming others in any way?	____	____

	YES	NO
Currently engaged in aggressive/violent behavior?	____	____
Have aggressive/violent thoughts?	____	____
Had aggressive/violent behavior or thoughts in the past?	____	____
Ever been hospitalized for psychiatric reasons?	____	____
Have any thoughts about harming themself in any way?	____	____

6. Psychological Symptoms (of Your Child/Adolescent)

PLEASE CHECK ALL THAT APPLY

Current		Past
☐	Depressed mood	☐
☐	Daily irritability	☐
☐	Lack of interest or pleasure in activities	☐
☐	Increase in appetite	☐
☐	Loss of appetite	☐
☐	Difficulty sleeping or poor sleep	☐
☐	Decreased need for sleep	☐
☐	Increased need for sleep	☐
☐	Tired or loss of energy	☐
☐	Feelings of worthlessness or guilt	☐
☐	Feelings of hopelessness	☐
☐	Recurrent thoughts of death	☐
☐	Racing thoughts or ideas	☐
☐	Distractibility	☐
☐	Rapid mood swings	☐
☐	Decreased ability to concentrate	☐
☐	Emotional/Psychological abuse	☐
☐	Physical abuse	☐
☐	Sexual abuse	☐
☐	Distressing memories that reoccur or intrude	☐
☐	Recurrent distressing dreams	☐
☐	Sense of reliving traumatic events	☐
☐	Periods of time you cannot remember	☐
☐	Intense reactions to certain events or anniversaries	☐
☐	Avoidance of thoughts or feelings of trauma	☐
☐	Avoidance of activities or situations of	☐
☐	Trauma	☐
☐	Detachment from feelings, people & places	☐
☐	Shortness of breath/dizziness	☐
☐	Accelerated heart rate or chest pains	☐
☐	Trembling or shaking	☐
☐	Sweating/feeling flushed	☐
☐	Choking	☐
☐	Nausea or abdominal distress	☐
☐	Feeling unreal	☐
☐	Numbness or tingling sensations	☐
☐	Fear of dying or going crazy	

Current		Past
☐	Excessive fear of persons,places, animal, objects, situations	☐
☐	Recurrent & persistent, thoughts	☐
☐	Behaviors excessively repeated	☐
☐	Bingeing/compulsive overeating	☐
☐	Intentional vomiting	☐
☐	Diuretics or laxative misuse	☐
☐	Excessive dieting	☐
☐	Compulsive exercising	☐
☐	Delusions (unreasonable thoughts or beliefs)	☐
☐	Hear or see things that other's don't?	☐
☐	Possess Special powers/attributes	☐
☐	Not able to control impulse to steal	☐
☐	Preoccupation with/or frequent gambling	☐
☐	Restlessness or inability to concentrate	☐
☐	Difficulty making decisions	☐
☐	Fatigue or loss of energy	☐
☐	Difficulty focusing attention	☐
☐	Difficulty completing tasks	☐
☐	Easily distracted	☐
☐	Disorganized in daily tasks	☐
☐	Forgetful in daily activities	☐
☐	Loses track of items	☐
☐	Continual need to be on the go	☐

☐ Other symptoms (describe)

☐ _____

☐ _____

☐ _____

7. Health/Medical Information

A..What medical problems or concerns, if any, are you currently having about your child/adolescent?

_____

_____

B. Are those problems being treated? ☐ Yes ☐ No By whom? _____

Last medical examination (date): _____ Primary care doctor: _____

What prescription or non-prescription drugs are you currently taking or have taken in the last six months?
1. (Med)_____ (Dosage)_____ (Taken for)_____
2. (Med)_____ (Dosage)_____ (Taken for)_____
3. (Med)_____ (Dosage)_____ (Taken for)_____

ALLERGIES: Drug, food, other (list) Type of reaction

_____ _____
_____ _____
_____ _____

Are their immunizations up to date? ☐ Yes ☐ No ☐ Unknown
Have they had dental problems in past year? ☐ Yes ☐ No
If yes, describe: _____
Are they currently pregnant? ☐ Yes ☐ No ☐ Unknown
Have they gained or lost more than 10 pounds in last year? ☐ Yes ☐ No
Do they have nutritional concerns? ☐ Yes ☐ No
How do you feel about your present weight? ☐ Satisfied ☐ Neutral ☐ Dissatisfied

Check any of the following that apply to your child/adolescent:

	Current	Past		Current	Past		Current	Past
Tuberculosis	☐	☐	Liver Disease	☐	☐	Heart Disease	☐	☐
Chronic Bronchitis	☐	☐	Ulcer (stomach)			Stroke	☐	☐
Emphysema	☐	☐	or Duodenus	☐	☐	Jaundice	☐	☐
Rheumatic Fever	☐	☐	Sexually transmitted			Hepatitis	☐	☐
Thyroid Disorder	☐	☐	disease	☐	☐	Asthma	☐	☐
Diabetes	☐	☐	Kidney Disorder	☐	☐	Anemia	☐	☐
Cancer	☐	☐	High Blood Pressure	☐	☐			
Epilepsy (Convulsions	☐	☐	Pancreatitis	☐	☐			

Other: _____

Are there any disabling conditions: Yes ___ No ___ If yes, describe: _____

Family history of serious illnesses, familial diseases: _____
_____

III. List past hospitalizations (including psychiatric), operations, or serious illnesses:

	Type of Illnesses/Operations	Year	Hospital or Doctor
A.	_____	_____	_____
B.	_____	_____	_____
C.	_____	_____	_____

_____ _____
Client's Signature Date

_____ _____
Therapist's Signature Date