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CHILD INFORMATION QUESTIONNAIRE

Today's Date: _____

Child's Name: _____ Age: _____

Address: _____ Birthdate: _____

_____Zip:_____ Soc. Sec.#_____

Home phone number of child: _____ OK to leave a message? _____

Person responsible for bill ? _____ Relationship to child: _____

Address: _____
Street City State Zip

Telephone: _____ (Home) - OK to leave a message? _____

_____ (Work) - OK to leave a message? _____

_____ (Cell) - OK to leave a message? _____

Child's Grade: _____ School: _____

How did you hear about us? _____ May we acknowledge the referral?

INSURANCE INFORMATION:

Policy #1

Name of Insured Person:_____ Relation to Client: _____

Date of Birth: _____ Social Security # _____

Insurance Company: _____ Policy #_____

Address for Claims: _____ Group #_____

_____ Employer: _____

Telephone Number: _____ Effective Date:_____

Policy #2

Name of Insured Person:_____ Relation to Client: _____

Date of Birth: _____ Social Security # _____

Insurance Company: _____ Policy #_____

Address for Claims: _____ Group #_____

_____ Employer: _____

Telephone Number: _____ Effective Date:_____

List of (full/half/step, etc.) siblings in order of age:

Name	Relationship	Age	Education	Occupation

Mother's Name: _____ Age:_____ Education:_____

Address: _____
Street City State Zip

Employed by: _____ Religious Preference:_____

Father's Name: _____ Age:_____ Education:_____

Address: _____
Street City State Zip

Employed by: _____ Religious Preference:_____

Parents' Marital Status:_____ Date Married:_____ Date Divorced:_____ (if applicable)

Date and cause of Parent Death(s) (if applicable):

Did mother or child have any difficulty at birth? If so, please explain:

Describe the problem with which you feel we can be of assistance :

When did you first notice this?

If the child has consulted a mental health professional in the past, please explain who and why:

What has been done about this problem thus far, and what were the results?

Describe any and all illnesses, injuries or operations the child has had:

Illness	Date	Any Lasting Effects
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What medications or special diets is the child presently using?

Are there other professionals who are familiar with this situation, past or present, such as physicians, hospitals, public health nurses, courts, or the Department of Family and Children's Services? Please specify:

Has any relative ever had any medical or emotional difficulty? Alcohol or drug problems? Please explain:

Has the child ever had or been treated for any of the following?

	Dates		Dates
Serious headaches	_____	Allergy to food or drugs	_____
Difficulty with hearing	_____	Bed wetting	_____
Difficulty with vision	_____	Frequent outbursts of anger	_____
Difficulty with talking	_____	Lying	_____
Fainting spells	_____	Stealing	_____
Serious head injury	_____	Poor concentration	_____
Weakness or fatigue	_____	Change in mood	_____
Meningitis, encephalitis	_____	Bowel trouble	_____
Crying spells	_____	Stomach trouble	_____
Sex problems	_____	Nail biting	_____
Unusual feelings	_____	Unusual fears	_____
Difficulty in sleeping	_____	Nightmares, bad dreams	_____
Nausea	_____	Difficulty walking	_____
"Sleep-walking"	_____	Drowsiness	_____
Hearing voices	_____	Poor appetite	_____
Hay fever, asthma	_____	Think people work against him or her	
High, prolonged fever	_____		_____

Please give details on the back of this page for any items you have marked.

Name of School:_____ Current Grade:_____

Teacher:_____ Grades Repeated:_____ Skipped:_____

Describe the child's current adjustment to school, school achievement, and any recent change in grades:

Describe the child's general adjustment:

Does the child have any hobbies or special interests? Yes _____ No_____
Explain:

Has the child ever been arrested? _____ Convicted of any crime?
If so, please explain:

Does the child drink? _____ Socially? _____ Alone? _____ How much and how often?
Does the child use drugs? _____ Socially? _____ Alone? _____
What type, how much and how often?

Does the child smoke cigarettes? _____ How much? _____ Age started:_____

If there is anything else you wish to share that has not been covered in this questionnaire, please do so below: