SOCIAL/MEDICAL QUESTIONNAIRE - CHILDREN/ADOLESCENTS

Patient _____ Date _____

Date of Birth ___/___/___ Age _____ Sex _____

Reason for bringing child at this time? _____

_____

_____

Who referred you to our office? _____

If this is a professional who referred you, do you give consent that we may acknowledge to this person/office that we have seen your child? ____ Yes ____ No

FAMILY HISTORY

Place of Birth _____ No. of Siblings _____ Child's No. In Family _____ Parents' Marital Status Now _____

Father's Name _____ Mother's Name _____

Address _____ Address _____

Phone: Home _____ Work _____ Phone: Home _____ Work _____

Stepmother _____ Stepfather _____

Address _____ Address _____

Phone: Home _____ Work _____ Phone: Home _____ Work _____

With whom does the child live? _____

Which parent has legal custody? _____ Mother _____ Father _____ Both _____ Neither

Household members of child's residence:

NAME	AGE	RELATIONSHIP TO CHILD	QUALITY OF RELATIONSHIP WITH CHILD

Child's brothers and sisters who are not in the same home as child:

NAME	AGE	SEX	QUALITY OF THE RELATIONSHIP WITH CHILD

If any brother/sister is deceased, give name and age at death: _____

Is the child adopted? _____ No _____ Yes If "Yes," at what age? _____

Has the child ever lived out of the home? _____ No _____ Yes If "Yes," explain where and why _____

In how many residences has the child lived since birth? _____

What is the child's race? _____ Black _____ White _____ Native American _____ Hispanic _____ Asian
_____ Other (specify) _____

What is the child's ethnic background? (e.g. Irish, English, German) _____

What is child's religion? ____ Catholic ____ Protestant ____ Jewish ____ Muslim ____ Hindu
____ Atheist ____ Agnostic ____ Other (specify) _____

Child's Father's Education _____ Occupation _____ Age _____ If Deceased, give year _____

Child's Mother's Education _____ Occupation _____ Age _____ If Deceased, give year _____

Is child's father currently employed? ____ Yes ____ No Is child's mother currently employed? ____ Yes ____ No

Does the child's family have financial problems? _____ No _____ Yes

Has the child ever been physically or sexually abused (circle which)? _____ No _____ Yes

Has the child ever physically or sexually abused anyone (circle which)? _____ No _____ Yes

Have the child's parents or any other family members had any mental health or alcohol/other drug problems?

_____ No _____ Yes If "Yes," describe who and what _____

Any other information about the home or family _____

EDUCATION

Child's school _____ Grade _____ Teacher _____

What are child's usual marks? _____ A _____ B _____ C _____ D _____ E

Is child now in a special program? _____ No _____ Yes If "Yes," describe _____

Has child been in a special program? _____ No _____ Yes If "Yes," describe _____

Has the child had any vocational training? _____ No _____Yes If "Yes," describe _____

Has child had any tutoring? _____ No _____ Yes If "Yes," explain _____

Has child been a behavior problem at school? _____ No _____ Yes If "Yes," explain _____

_____

VOCATIONAL

Does the child work? ____ Yes ____ No If "Yes," what job? _____ For how long? _____

SOCIAL RELATIONSHIPS/LEISURE TIME

Does child have? _____Friends _____ Acquaintances _____ Both

How often does child see friends? _____ Daily _____Frequently _____ Infrequently _____ Rarely

How does child spend <u>most</u> leisure time? _____ Alone _____ With Others _____ About Equal

List child's hobbies, leisure time activities, interests and talents: _____

_____

Which does child like best? _____

LEGAL PROBLEMS

Has child been involved with the police/courts? _____ Yes _____ No If "yes," specify the

CHARGE	DATE	OUTCOME	WAS THIS RELATED TO ALCOHOL OR OTHER DRUG USE?

_____

_____

MEDICAL/HEALTH INFORMATION

Describe the child's general physical health: _____ Good _____ Fair _____ Poor
When was child's last physical exam? (month) _____ (year) _____
I can't remember the exact date, but it was approximately _____ years ago.
Reason for last physical exam _____

Name of child's physician _____
Address _____ Phone _____

Pregnancy:

Were there complications? Yes _____ No _____ If "Yes", please explain _____
_____

How long was pregnancy? _____ months How long was active labor? _____ hours

Was baby premature? _____ No _____ Yes If "Yes," how early? _____ months

Type of delivery (check one) _____ Spontaneous _____ Forceps _____ Caesarean

Was baby born (check one)? _____ Head First _____ Feet First (Breech)

Indicate if baby was given: _____ Blood Transfusion _____ X-Ray _____ Electroencephalogram (EEG)

Baby's weight at birth was _____ pounds _____ ounces

Indicate the child's condition in the first two weeks of life. Write the letter "Y" (Yes), "N" (No) or "U" (Unknown):

_____Yellow Appearance _____ Blue Lips _____ Vomiting _____Difficulty Breathing
_____ Feeding Difficulty _____ Irritable _____ High Fever _____Deformed Physically
_____ Slow Responding _____Convulsions/Twitching

Infancy/Childhood/Adolescence:

Was the infant breast fed? No _____ Yes _____ If "Yes," until what age? _____
Did the infant feed well? Yes _____ No _____ If "No, explain _____
Was the infant's weight gain normal? _____ Yes _____ No

Indicate age child: _____ Stood Alone _____Walked Alone _____ Used Words
_____ Spoke Sentences _____ Bladder Trained _____ Bowel Trained
_____ Began puberty/ first menstruation _____

Check all of the following conditions that apply to the child after the first two weeks of life:

____ Vomiting ____ Diarrhea ____Constipation ____ Colic
____ Thyroid Problems ____ Headaches ____ High Fevers ____ Low Blood Sugar
____ Diabetes Mellitus ____ Chest Pains ____ High Blood Pressure ____ Trouble Sleeping
____ Seizures ____ Asthma ____ Attention Problems ____ Nightmares
____ Other(s) (specify) _____

Describe child's sleep generally _____ Good _____ Fair _____ Poor

Does the child have allergies? ____No ____ Yes If "Yes," list them _____
_____

Has child ever had an allergic reaction to a food, medicine, environmental stimulus (e.g. dust, grass) drug or alcohol?
____ No ____ Yes if "Yes," to what? _____

List all serious illness, injuries, accidents and surgeries child has had:

Illness, Injury, Accident, etc.	Child's Age	Hospitalized (Yes or No)	How Long in Hospital?

Any contagious or other diseases? ____ No ____ Yes If "yes," which? _____

Check problems that apply to the child? ____ Speech/Language ____ Hearing ____ Vision
____ Motor Coordination ____ Disability/Handicap

Check those that child eats: ____ Meats ____ Fruits and Vegetables ____ Dairy Products ____ Breads
Describe child's appetite: ____ Good ____ Fair ____ Poor
Does the child eat regularly? ____ Yes ____ No

Has child had all required immunizations (DPT, TOPV, MMR, TD)? ____ Yes ____ No

List any illnesses that run in child's family: _____

EMOTIONAL HEALTH

Has your child had treatment/evaluation of emotional/behavioral, learning or school-related problems?
_____ Yes _____ No

If "Yes," was it:

____ Outpatient ____ Inpatient ____ Day Hospital ____ Substance Abuse
____ Mental Health ____Psychological Testing ____ Psychiatric Evaluation

Name of Center/Individual	Address	Year
1.		
2.		
3.		

Has child ever made a suicide attempt? ____ No ____ Yes If "Yes," in what year(s)? _____

Has child ever had homicidal thoughts or experienced explosive, uncontrolled anger? ___ No ___ Yes If "Yes," describe:
_____
_____

Has the child recently made suicidal/homicidal comments? ____ No ____ Yes If "Yes," explain: _____
_____
_____

Has the child ever engaged in purposeful self-harm (e.g. cutting, burning self, etc.) ____ No ____ Yes
If "Yes," explain: _____
_____

MEDICATION/SUBSTANCE USE

List all medications, alcohol and drugs patient takes or has taken:

Prescriptions	Over-the-Counter	Street Drugs

ANY OTHER INFORMATION YOU WOULD LIKE TO ADD

_____

_____

_____

_____
Signature of Informant Date

_____
Relationship to Patient

I have reviewed this questionnaire with the patient/informant:

_____
Clinician's Signature/Credentials Date