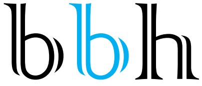


BALANCE BEHAVIORAL HEALTH, PLLC

CHILD QUESTIONNAIRE (ages 1-12)

Please answer the following questions as completely as possible

Child's Name ____ M ___ F ___ Birth Date____________________

Today's Date________________________ Form completed by____

Your relationship to the child____

Child's School/Daycare____ Grade______________________

Child's Primary Physician____ Phone_______________________

When did your child last see a physician?___________________ The reason?_____________________________

____

Does your child have any chronic or serious illnesses? If so, please describe:_________________________________

____

List any medications your child is regularly taking, or has taken:

NAME DOSAGE FREQUENCY DATE STARTED/ENDED MD

____

____

____

Has your child ever been hospitalized? If yes, briefly explain: ____

____

FAMILY INFORMATION:

Mother's Name____ Birthdate______________________

Mother's Occupation_______________________________ Education_______________________________________

Living in Home? Yes_____ No_____ If no, please explain____

____

Father's Name____ Birthdate______________________

Father's Occupation_______________________________

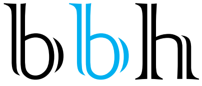
Education___________________________________

Living in Home? Yes_____ No_____ If no, please explain____

____

With whom does the child live? Birth parents_________ Foster Parents_________ Adoptive Parents___________

Other (specify)____



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List all other persons living in the home:

NAME	DOB	RELATIONSHIP TO CHILD	SEX	GRADE/JOB

List any other people who care for the child a significant amount of time (neighbor, babysitter, grandparent, etc.)

NAME	RELATIONSHIP TO CHILD

CHILD'S DEVELOPMENTAL HISTORY:

Pregnancy and birth, any problems? No_____ Yes_____ If yes, briefly explain:_________________________________

____

Was the child adopted?_______ If yes, at what age?_________ What history/information is known about the birth parents?

____

Developmental milestones (at what ages were these met?)

Sitting ____________ Walking ___________ Talking ___________ Toilet Trained ___________

Medical Problems? No________ Yes________ If yes, briefly explain ______________________________________

____

____

Please list any jobs or chores your Child has in the family or at school. (feeding the dog, taking out trash, Safety patrol). If none_________

How well does your child do these jobs or chores?

Poor		Average		Great
1	2	3	4	5

1. ____ ____

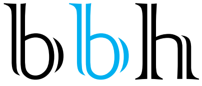
2. ____ ____

3. ____ ____

Comments____

____

____



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Compared to other children his/her age, how does your child get along with other children?

Poor		Average		Great
1	2	3	4	5

What are your child's favorite recreational or extracurricular activities?

____

____

Who generally disciplines the child? ____

What methods are used?____

Do parents agree about method of discipline? Yes_____ No______ If no, please explain: ________________________

____

____

SCHOOL HISTORY:

Has child been enrolled in preschool or daycare? _________ What age? ___________

Has child attended kindergarten? _______________ What age?________________

Has child begun elementary school? __________ At what age did he/she enter first grade?____________

What is the present school grade?___________________________

If your child has been to school (including preschool, kindergarten, elementary, etc.), complete the following for all classes and end with the current placement. Please comment if your child repeated a grade or is in a special class (gifted, learning disabled, curriculum assistance, behaviorally/emotionally handicapped, etc.)

GRADE SCHOOL COMMENTS

____

____

____

____

____

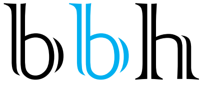
____

____

____

____

____



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Current school performance (for children aged 6 and older):

	Failing	Below Average	Average	Above Average
Reading	____________	______________	_______________	______________
Writing	____________	______________	_______________	______________
Math	____________	______________	_______________	______________
Spelling	____________	______________	_______________	______________

Other academic subjects (History, Science, Art, Music, Languages, etc.)

	Failing	Below Average	Average	Above Average
__________	____________	______________	_______________	______________
__________	____________	______________	_______________	______________
__________	____________	______________	_______________	______________
__________	____________	______________	_______________	______________

Behavior problems in school? ____

____

____

PARENT CONCERNS:

What do you think is your child's main problem? ____

____

____

____

____

When did these problems begin? ____

____

What do you think caused your child's problem(s)?____

____

____

What have you been told by doctors, teachers, and/or others about your child's problem(s)?_________________________

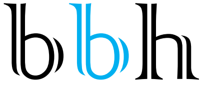
____

____

Has this child had any other mental health evaluations or treatment?____

____

____



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Educational evaluations, occupational or physical therapy, or speech or language evaluations?_____________________

___

___

Has any other member of the child's immediate family had mental treatment?___________________________________

___

___

___

Please describe any marital problems or family stresses which may contribute to your child's problem:________________

___

___

___

What has been done so far to try to deal with your child's problems?____

___

___

___

Please list any special strengths or talents that your child has:

___

___

___

Any other information that you think may be helpful about your child:

___

___

___

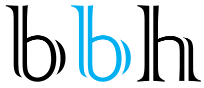
___

___

___

___

___



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Symptom Checklist

Please check all of the following problems/symptoms which pertain to your child.

( ) panicky feelings
( ) nervousness
( ) anxiety
( ) fears
( ) phobic avoidance
( ) procrastination
( ) nervous tics
( ) driven to perform certain behaviors
( ) headaches
( ) chest pains
( ) rapid heart beat
( ) dizziness
( ) excessive sweating
( ) appetite problems
( ) weight loss/gain
( ) bowel/stomach trouble
( ) binging
( ) vomiting
( ) purging
( ) muscle tension
( ) physical pain

( ) problems with authority
( ) depression
( ) unhappiness
( ) seasonal variations in mood
( ) tearfulness
( ) loss of interest
( ) sleep problems
( ) nightmares
( ) fatigue
( ) low self-esteem
( ) memory problems
( ) reduced concentration
( ) withdrawal
( ) no sense of purpose
( ) shyness
( ) loneliness
( ) relationship problems
( ) racing thoughts
( ) educational problems
( ) boredom
( ) temper outbursts
( ) loss of control

( ) suspicious of others
( ) hearing unidentified voices or sounds
( ) guilt
( ) jealousy
( ) difficulty making decisions
( ) homicidal thoughts
( ) suicidal thoughts
( ) history of abuse
( ) flashbacks
( ) time loss
( ) feeling out of body
( ) feeling unreal
( ) smelling unidentified odors
( ) sensitivity to noise or lights
( ) hearing problems
( ) menstrual problems

THANK YOU FOR YOUR TIME AND COOPERATION!