MELBOURNE
INTEGRATIVE PSYCHOLOGY
3270 Suntree Blvd., Suite 216
Melbourne, FL 32940
321-757-4058

Child/Adolescent History Questionnaire

- *Please print and complete this form and bring it to your first session*
- *Please print, complete and also bring your completed **Child Checklist of Concerns**.*
- *Please bring your insurance card and a photo ID.*
- *Leave blank any question you would rather not answer.*
- *If any question does not apply to you, please put "N/A".*

I. Identifying Information

Child's full name: ____

Child's parents or guardians: ____

Age: _____ Date of birth: _____________ Social Security No. ________________

Address: ____

____

Home telephone number (with area code): _____________________________________

Please list the individuals currently living with your child:

Name	*Age*	*Relationship*

Biological family members not living with child:

Name	*Age*	*Relationship*

II. Referral and Prior Treatment

Who referred you to this office? ____

What is are your primary concerns with your child at this time?

____

____

____

What have you tried already to deal with this problem or situation?

____

____

What would you describe as your child's primary strengths?

____

____

Has your child ever received behavioral health treatment? *(If yes, please list the reason, provider, place, and dates of therapy)* ____

____

____

Has your child ever been hospitalized for emotional problems? *(If yes, please list the reason, hospital, place, and dates)* ____

____

____

III. School Information

School ________________________________ Grade _____ Placement ________

Teacher's Name ________________________ Principal ______________________

How is your child performing in school and are there any school concerns? __________

____

IV. Developmental History

Length of pregnancy (weeks) ____________ Mother's age at birth of child ______

Length of delivery (hours) ____________ Child's birth weight _____________

Did any of the following conditions affect your child during delivery or within the first few days after birth?

Yes	No		Yes	No	
____	____	Injured during delivery	____	____	Cardiopulmonary distress
____	____	Delivered with cord around neck	____	____	Medication to ease labor
____	____	Needed oxygen	____	____	Was cyanotic (blue)
____	____	Was jaundiced (yellow)	____	____	Had an infection
____	____	Had seizures	____	____	Given medications
____	____	Born with a congenital defect	____	____	Was in hospital >7 days

During the first twelve months was your child:

Yes	No		Yes	No	
____	____	Difficult to feed	____	____	Difficult to get to sleep
____	____	Colicky	____	____	Difficult to put on a schedule
____	____	Alert	____	____	Cheerful
____	____	Affectionate	____	____	Sociable
____	____	Easy to comfort	____	____	Difficult to keep busy
____	____	Overactive	____	____	Stubborn (challenging)

At what age did your child first accomplish the following:

Sitting without help __________________________ Crawling ____________________

Using single words ____________________________ Walking ____________________

Putting two or more words together ______________ Toilet training ________________

V. Medical History

Does your child have any major medical problems? *(If yes, please describe below):*

____

____

____

Has your child ever been hospitalized for medical problems? *(If yes, please list where, when, and for how long):* ____

____

____

Please provide the name, address, and phone number of your child's pediatrician:

____

____

____

What medications is your child currently taking:
____

Has mental retardation ever been diagnosed or suspected? ____________________________

Please check whether your child has had any of the following health problems:

Present	*Past*	*Never*	
________	________	_______	Asthma
________	________	_______	Allergies
________	________	_______	Diabetes, Arthritis, or Chronic Illnesses
________	________	_______	Epilepsy or seizure disorder
________	________	_______	Febrile seizures
________	________	_______	Chicken pox or other childhood illness
________	________	_______	Heart or blood pressure problems
________	________	_______	High fevers (over 103 degrees)
________	________	_______	Broken bones
________	________	_______	Severe cuts requiring stitches
________	________	_______	Head injury with loss of consciousness
________	________	_______	Lead poisoning
________	________	_______	Surgery
________	________	_______	Lengthy hospitalizations
________	________	_______	Speech or language problems
________	________	_______	Chronic ear infections
________	________	_______	Hearing difficulties
________	________	_______	Eye or vision problems
________	________	_______	Fine motor problems (ex. handwriting)
________	________	_______	Gross motor problems (ex. clumsiness)
________	________	_______	Appetite problems
________	________	_______	Sleep problems
________	________	_______	Soiling problems
________	________	_______	Wetting problems
________	________	_______	Other health difficulty (describe)

Is there anything else you feel would help me understand your situation better?_________
____
____

Thank you!
Please bring this with you to your appointment.