seascape counseling
navigating life's transitions

9404 Genesee Avenue, Suite 245
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Child/Adolescent Questionnaire

(to be completed by parent/guardian regarding the child/teen whom you are seeking help)

Clients Name **Age** **Date of Birth** **Today's Date**

_____

Address **home phone** **cell phone**

_____

_____

Parent/Guardian Names **Marital Status** **Work Phone**

_____

_____

Mother:

_____

Father:

_____

Stepmother:

_____

Stepfather:

_____

Other:

_____

If you are divorced/separated, is there a custody order? _____Yes_____No

(if so, and only one parent is present for the intake, you will be asked to produce a copy of the custody order prior to any subsequent appointments.)

Siblings/Other Household Member's Name **Age** **Relationship to Child**

_____

_____

_____

_____

Languages Spoken at Home:

_____

Please describe why you are seeking treatment?

_____

_____

_____

When did the problem start?

_____

How would you rate the severity of the problem right now?

Mild 0 1 2 3 4 5 6 7 8 9 10 Severe

Problem Checklist

Please indicate which of the problems below are bothering the child at this time:

0= none 1=mild 2=moderate 3=serious 4=severe

0 1 2 3 4 Suicidal Thoughts/behaviors
0 1 2 3 4 Self Harm
0 1 2 3 4 Feels Hopeless
0 1 2 3 4 Feels Worthless
0 1 2 3 4 Irritable
0 1 2 3 4 Sad/Tearful
0 1 2 3 4 Moody
0 1 2 3 4 Bully
0 1 2 3 4 Poor sleep
0 1 2 3 4 Too much sleep
0 1 2 3 4 Night Mares
0 1 2 3 4 Poor concentration
0 1 2 3 4 Excessive worry/fears
0 1 2 3 4 Panic
0 1 2 3 4 Irregular eating habits
0 1 2 3 4 Weight preoccupation
0 1 2 3 4 Nail biting
0 1 2 3 4 Repetitive behaviors
0 1 2 3 4 Thumb sucking
0 1 2 3 4 Soiling in pants
0 1 2 3 4 Bed wetting
0 1 2 3 4 Attention seeking
0 1 2 3 4 Stuttering

0 1 2 3 4 Hears Voices
0 1 2 3 4 Sees things not there
0 1 2 3 4 Fits of rage
0 1 2 3 4 Overly suspicious
0 1 2 3 4 Few friends
0 1 2 3 4 Excessively shy
0 1 2 3 4 Bossy
0 1 2 3 4 Overly sensitive
0 1 2 3 4 Teases others
0 1 2 3 4 Teased by others
0 1 2 3 4 Cruel to others/animals
0 1 2 3 4 Lying
0 1 2 3 4 Stealing
0 1 2 3 4 Fire setting
0 1 2 3 4 Runs away
0 1 2 3 4 Aggression
0 1 2 3 4 Truancy
0 1 2 3 4 Sexual acting out
0 1 2 3 4 Legal problems
0 1 2 3 4 Authority conflicts
0 1 2 3 4 Tics
0 1 2 3 4 Accident prone
0 1 2 3 4 Excessive physical complaints

Child's Birth and Early Development

Was the pregnancy planned? **Yes** **No**
Is the child adopted? **Yes** **No**

Were any of these substances used during pregnancy?

Alcohol	Yes	No
Drugs	Yes	No
Cigarettes	Yes	No

If YES please specify_____

How was mother's health during pregnancy?

_____

_____

Birth Weight_____ Premature_____yes _____no

Type of delivery?_____Problems at birth?_____

Feeding difficulties?

_____

Sleeping difficulties?

_____

Breast Fed _____ months **Bottle Fed_____months**

As an infant, did your child have regular sleeping and eating habits? Yes No

_____

Age when child……..

Sat alone _____ Walked alone_____ Spoke first words_____
Crawled _____ Toilet trained_____ Bowel trained_____
Spoke first phrases _____ Spoke first sentences_____

_____

Anything unusual or unique about speech development?

_____

Describe your child's personality through out early childhood.

_____

_____

Medical History

Please describe all serious illnesses, accidents and surgeries:

_____

_____

illness, accident, surgery	age	hospital stay?	How long?

Any Medical concerns?

Seizures	Yes	No
Eye Problems	Yes	No
Hearing Problems	Yes	No
Blackout spells	Yes	No
Other	Yes	No

Prior psychiatric/psychological treatment, hospitalization or medication? _____ Yes _____No

If YES, where and when_____

_____

Current medications/ doses_____

_____

_____

List all drug allergies/adverse reactions_____

_____

Drug and Alcohol History

Past or present history of drug or alcohol abuse: Yes No

If YES, please describe

_____

_____

Has your child experimented with alcohol or drugs? Yes No

Has your child had any police/legal involvement? _____Yes _____No

If yes, please describe._____

_____

_____

School History

_____

Name of School:

_____

Teacher:

_____

Counselor:

_____

Grade:

_____

Please circle Yes or No to all responses regarding your child's school experiences:

Learning disabilities	Yes	No
Academic Achievement problems	Yes	No
School avoidance/phobia	Yes	No
Truancy	Yes	No
Behavior problems	Yes	No
Peer problems	Yes	No
IEP	Yes	No
504 plan	Yes	No

Has your child been achieving about as well as you feel he or she should?

Yes **No**

What best describes the grades he or she usually gets?

_____ Well above average

_____ Somewhat above average

_____ Average

_____ Somewhat below average

_____ Well below average

About how much time does your child spend on homework nightly?

_____

Does your child participate in extracurricular activities?

_____

Has your child ever been evaluated for ADHD or other learning problems? If so, When, where and by whom?

_____

_____

Family History

Who had been the primary caregiver of the child?

_____

Any significant separations during the first three years?

_____

How does your child gets along with others? mark the scale from 1-10
1 being "gets along very poorly " and 10 being "gets along very well"

Mother: *1 2 3 4 5 6 7 8 9 10*

*Details*_____

_____

Father: *1 2 3 4 5 6 7 8 9 10*

*Details*_____

_____

Stepmother: *1 2 3 4 5 6 7 8 9 10*

*Details*_____

_____

Stepfather: *1 2 3 4 5 6 7 8 9 10*

*Details*_____

_____

Siblings: *1 2 3 4 5 6 7 8 9 10*

*Details*_____

_____

Other family *1 2 3 4 5 6 7 8 9 10*

*Details*_____

_____

Is there any family history of mental illness, developmental disabilities, alcohol/drug abuse, psychiatric treatments or hospitalizations? If so please specify and describe._____

_____

_____

Has violence been a part of the marriage or any other important relationship in the child's life? If yes, describe

_____

_____

Is there currently any physical violence or verbal abuse in your home?

_____Yes _____No

If yes, describe

_____

_____

Has your child been the victim of sexual, physical, emotional or verbal abuse?

_____ Yes _____ No

Significant Events in the Child's Life

1.	Death of a parent	Yes	No
2.	Parents' divorce	Yes	No
3.	Parents' separation	Yes	No
4.	Death of a close family member	Yes	No
5.	Major personal injury or illness	Yes	No
6.	Illness of a family member	Yes	No
7.	Change of schools	Yes	No
8.	Pregnancy	Yes	No
9.	Sexual problems	Yes	No
10.	Death of a close friend	Yes	No
11.	Serious relationship problems	Yes	No
12.	Sibling leaving home	Yes	No
13.	Frequent change of residence	Yes	No

Please give the # of any YES items and explain

_____

_____

_____
_____
_____

What would you like to get from your child's/family's treatment here?

_____
_____
_____
_____
_____
_____

Parent/Guardian signature **Date**

_____
_____

thank you