COMPREHENSIVE COUNSELING SERVICES
1115 First Street, S.W. *Phone (540)343-0004*
Roanoke, VA 24016 *Fax (540)343-1576*

CHILD/ADOLESCENT QUESTIONNAIRE

CHILD'S NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____

Referred by: _____

Child's School: _____ Teacher's Name: _____

School Address: _____

School Phone: _____ Child's Grade: _____

Is child in special educations? YES NO If yes, what type? _____

Is this child: _____ Your biological child _____ Adopted _____Foster child
Are parents married? YES NO Separated? YES NO Divorced? YES NO
With which parent does the child live? _____ Both? _____Mother only _____Father only
Neither parent, Child lives with: _____ Grandparent _____in foster care _____Other

Are family members willing to participate in counseling? YES NO

Has child ever lived outside the home (in foster care, with a relative, with a friend, etc.)?
YES NO If yes, please explain: _____
_____
_____

Household Members:

Name	Age	Relationship	School Grade (if applicable)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

KNOWN ALLERGIES: _____

_____

Previous Counseling, Psychiatric Hospitalization or Chemical Dependency Treatment: _____ None

Place/Therapist	Date	Reason	Was it Helpful?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family Psychiatric History (if any):_____

_____

Child's Physician: _____
Physician's Address: _____
May we contact your child's physician to coordinate services? Yes No

Current Medications:

Medications	Dosage	Prescribing M.D.	Start Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parental Concerns About Child—What Brings You to Counseling?

A. List your concerns regarding your child's behavior at home:

B. List your concerns regarding your child's emotional health:

C. What problems has your child had with his/her development from birth to present?

D. What behavioral/social problems has your child had at school (include preschool and day care)?

E. What academic/learning problems does your child currently have or had in the past?

F. What problems has your child had in the community (include any legal problems and court status, if any)?

G. Other concerns:

What changes would you like to see as a result of counseling?

Developmental and Medical History:

A. Length of pregnancy: _____ full term _____premature
B. Length of delivery (number of hours from initial labor pains to birth): _____
C. Mother's age when child born: _____
D. Child's birth weight: _____
E. Did any of the following occur during pregnancy/delivery:

1. Bleeding	No	Yes
2. Excessive weight gain (more than 20 pounds)	No	Yes
3. Toxemia/Preeclampsia	No	Yes
4. Rh factor incompatibility	No	Yes
5. Frequent nausea or vomiting	No	Yes
6. Serious illness or injury	No	Yes
7. Took prescription medications	No	Yes
If yes, name of medications _____		
8. Took illegal drugs	No	Yes
9. Used alcoholic beverages	No	Yes
If yes, number of drinks per week: _____		
10. Smoke cigarettes	No	Yes
11. Was given medication to ease labor pains	No	Yes
12. Delivery was induced	No	Yes
13. Forceps used during delivery	No	Yes
14. Had a breech delivery	No	Yes
15. Had Cesarean section delivery	No	Yes

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

1. Injured during delivery	No	Yes
2. Cardiopulmonary distress during delivery	No	Yes
3. Delivery with cord around neck	No	Yes
4. Had trouble breathing following delivery	No	Yes
5. Needed oxygen	No	Yes
6. Was jaundiced (turned yellow)	No	Yes
7. Had an infection	No	Yes
8. Had seizures	No	Yes
9. Was given medications	No	Yes
10. Born with congenital defect	No	Yes
11. Was hospitalized for more than 7 days	No	Yes

Infant/Toddler Health and Temperament:

A. During the first 24 months, was your child:

1. Difficult to feed	No	Yes
2. Difficult to get to sleep	No	Yes
3. Colicky	No	Yes

4. Difficult to put on a schedule No Yes
5. Alert No Yes
6. Cheerful No Yes
7. Affectionate No Yes
8. Sociable No Yes
9. Easy to comfort No Yes
10. Overactive, in constant motion No Yes
11. Very stubborn, challenging No Yes

Early Developmental Milestones:

At what age did you child first accomplish the following?

1. Sitting without help _____.
2. Crawling _____.
3. Walking alone without assistance _____.
4. Using single words (i.e. mama, dada, ball, etc.) _____.
5. Putting two or more words together _____.
6. Bowel training: day_____ night _____.
7. Bladder training: day _____ night _____.
8. Sleeping through the night_____.

Health History:

A. Date of child's last physical exam _____.
B. Has your child had any of the following?:

1. Asthma Past Present Never
2. Allergies Past Present Never
3. Diabetes, arthritis or other chronic illnesses Past Present Never
4. Epilepsy Past Present Never
5. Seizures in infancy (febrile seizures) Past Present Never
6. Chicken pox/other childhood illnesses Past Present Never
7. Heart or blood pressure problems Past Present Never
8. High fevers (over 103 degrees) Past Present Never
9. Broken bones Past Present Never
10. Severe cuts requiring stitches Past Present Never
11. Head injury with loss of consciousness Past Present Never
12. Lead poisoning Past Present Never
13. Surgery Past Present Never
14. Lengthy hospitalization Past Present Never
15. Speech or language problems Past Present Never
16. Chronic ear infections Past Present Never
17. Hearing difficulties Past Present Never
18. Eye or vision problems Past Present Never
19. Fine motor/writing problems Past Present Never
20. Gross motor difficulties/clumsiness Past Present Never

21.Appetite problems (overeating/under eating)	Past	Present	Never
22.Sleep problems (falling asleep/staying asleep)	Past	Present	Never
23.Soiling problems	Past	Present	Never
24.Wetting problems	Past	Present	Never

25.Please list other health problems: _____
_____
_____

CURRENT SYMPTOMS: (please circle)

Anhedonia
Anger
Anorexia
Anxiety
Crying
Appetite Disturbance
Weight Loss
Weight Gain
(# Of pounds_____)

Defiance
Delusions
Depression
Derealization
Depersonalization
Flashbacks
Grandiosity
Guilt
Hallucinations
Helplessness
Homicidal Ideation
Hopelessness
Hostility/Belligerence
Impaired Concentration
Inattention
Other features (Specify): _____

Impaired functioning: School/Family
Impulsiveness
Irritability
Lability
Lack of Assertiveness
Lack of Interest
Mood Swings
Nightmares
Obsessive/Compulsive
(Specify: Thoughts/Actions):
_____
Panic Attacks
Paranoia
Phobia
Social Withdrawal
Sleep Disturbance
Hypersomnia
Insomnia
Suspiciousness
Tantrums
Excessive Worry
Stealing
Fighting
Poor Social Skills
Feeling of Inadequacy