Authenticity Counseling

6409 Odana Road, Suite 24 | Madison, WI 53719
tricia@authenticitycounseling.com | (608) 628-7147

CHILD HISTORY QUESTIONNAIRE

Please bring this completed form to your initial appointment.

Client's Name:	Gender:	Birth Date:	Age:
Form Competed by (if other than client):		E-mail:	
Today's Date:	Home Phone:		
Address:	Cell Phone:		
City:	State:	Zip:	
Primary Care Provider (PCP):		PCP Clinic:	
PCP Phone:		PCP Fax:	
Referral Source:			

May we leave a message on your: ☐ home phone ☐ cell phone
May we send mail to your home: ☐ yes ☐ no
May we e-mail you: ☐ yes ☐ no
*please note that email is not considered to be a confidential means of communication

Parent/Guardian Information

Mother _____ Sole Custody ☐ Joint Custody
(name) *(best contact number)*

Father_____ Sole Custody ☐ Joint Custody
(name) *(best contact number)*

What are the concerns that brought you here? _____
_____
_____
_____

Is your child currently experiencing struggles with:

☐ Anger
☐ Anxiety / Worry
☐ Appetite
☐ Concentration
☐ Depression / Sadness
☐ Energy Level
☐ Family Problems
☐ Friendships
☐ Panic
☐ Sleep
☐ Suicidal Thoughts
☐ Weight
☐ Health Problems (specify):_____
_____
☐ Other (explain):
_____
_____
_____

Has your child been in therapy in the past? _____Yes _____ No
If so, who did you see, and when?

_____

_____

If yes, was the therapy beneficial? _____

Has your child ever been prescribed medication for mental health issues? If so, please list:

_____

Is your child currently taking any prescription medications for physical or mental health issues? If so, please list: _____

_____

Is your child currently taking any over-the-counter medications, aspirins, herbs, and/or vitamins? If so, please list: _____

_____

Please list what you eat in a typical day:
Breakfast: _____Dinner: _____
Lunch:_____ Snacks: _____

History of Behaviors:

- ☐ Aggression to animals
- ☐ Aggression to people
- ☐ Anger
- ☐ Antisocial behavior
- ☐ Anxiety
- ☐ Arguing
- ☐ Avoiding people
- ☐ Compulsions / Obsessions
- ☐ Concentration problems
- ☐ Conflict with others
- ☐ Depression
- ☐ Destruction of property
- ☐ Disorganized thinking
- ☐ Disorientation
- ☐ Dizziness
- ☐ Elevated mood
- ☐ Encopresis
- ☐ Enuresis
- ☐ Family Problems
- ☐ Fatigue
- ☐ Friendship problems
- ☐ Gang involvement
- ☐ Grades inconsistent / low
- ☐ Guilt
- ☐ Hallucinations
- ☐ Headaches / Migraines
- ☐ Heart palpitations
- ☐ Homicidal thoughts
- ☐ Hopelessness
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Internet addiction
- ☐ Interrupts frequently
- ☐ Irritability
- ☐ Judgment errors
- ☐ Loneliness
- ☐ Loses temper
- ☐ Low motivation
- ☐ Low self esteem
- ☐ Lying
- ☐ Memory problems
- ☐ Mood changes
- ☐ Nightmares / Night terrors
- ☐ Panic attacks
- ☐ Phobias / Fears, of what:_____
- ☐ Running away
- ☐ School refusal
- ☐ Sick frequently
- ☐ Skipping school / Missing work
- ☐ Sleeping too much / too little
- ☐ Speech problems
- ☐ Stealing
- ☐ Stomach aches
- ☐ Suicidal thoughts
- ☐ Withdrawing
- ☐ Worrying
- ☐ Other (specify):

_____

_____

_____

Has your child ever talked about or attempted suicide? ☐Yes ☐No

If yes, when: _____

Has your child ever engaged in self-mutilation? □Yes □No

If yes, when: _____

Does your child talk about harming someone else? □Yes □No

If yes, when, how, and who? _____

Has your child ever been hospitalized for psychiatric problems?

If yes, when? _____

Reason?_____

Has your child ever been hospitalized for medical problems?

If yes, when? _____

Reason?_____

Has your child ever been:

Sexually abused □ Yes □ No If yes, Age / By Whom: _____

Physically abused □ Yes □ No If yes, Age / By Whom: _____

Neglected □ Yes □ No

Does your child get along with his/her parents? _____

_____

_____

Is your child having any problems with his/her siblings / family? (if applicable) _____

_____

_____

PARENTING:

What strengths do you as the parent have? _____

_____

What deficits do you have in your parenting style?_____

_____

What types of rules and consequences do you use with your child? _____

_____

Who does your child live with? (check all that apply)

□ Alone
□ Parent(s)
□ Stepmom / Stepdad
□ Brother(s)
□ Sister(s)
□ Step brother(s)
□ Step sister(s)
□ Half brother(s)
□ Half sister(s)
□ Roommate(s)
□ Other (specify):_____ _____

Is your child safe in his/her current living situation? □ Yes □ No _____

Is there a history of mental health problems in your child's biological family? □ Yes □ No

If yes, who/what? _____

_____

Significant Childhood Stressors: (Check any that apply)

□ Death of parent: Client Age _____

□ Death of Sibling: Client Age _____

□ Parent Divorce: Client Age _____

□ Physical/Sexual abuse: Client's age & Duration _____

□ Domestic Physical Violence in the home: _____

□ Family Alcoholism/Drug Abuse or Dependency: One Parent Both Parents Other

□ Other Stressors: _____

Ethnicity & Religion

What is your cultural / ethnic background? _____

Do you consider yourself to be spiritual / religious? □ Yes □ No

Education

What grade is your child currently in? _____

Where does he/she go to school? _____

Attendance problems? □ No □ Yes _____

History of Behavior Problems at School? □ No □ Yes _____

_____

_____

Special Education Instruction: □ No □ Yes _____

School Contact Person _____

What does your child typically do for fun / hobbies? _____

_____

How often does your child socialize with friends outside of school? _____

How many hours per day does your child spend on Facebook / Twitter / Internet, etc ? _____

How many hours per day does your child spend watching TV? _____

How many hours per day does your spend playing video games? _____

How much / often does your child text? _____

How many hours per night does your child sleep? _____

What your child's bedtime? _____Wake up? _____Do you have a regular routine? □Yes □No

Does your child wake up in the middle of the night? _____

Pregnancy

How old was the mother at the time of this child's birth?_____

How old was the father at the time of this child's birth? _____

Was this pregnancy planned □ or □ unplanned or □ unknown

Did the child's mother use alcohol during pregnancy? □ yes □ No □ unknown
If yes, how much/often _____
Did the child's mother smoke during pregnancy? □ yes □ No □ unknown
If yes, how much/often _____
What medications were used by the child's moth during pregnancy?
□ none □ unknown □ (list)_____
What illnesses did this child's mother have during pregnancy?
□ none □ unknown □ (list)_____

Birth

How long was the pregnancy? □ full-term □ not full-term (length)_____
How long did labor last? _____
What type of delivery? □ unknown □ induced □ vaginal □ cesarean
Child's birth weight? _____ Apgar Score (if known) _____
Parent's Reaction to child's birth
Mother: □ happy □ unhappy □ mixed feelings □ unknown
Father: □ happy □ unhappy □ mixed feelings □ unknown
Were there complications with the delivery? □ no □ yes, please explain _____
_____

Did this child meet developmental milestones within the average time frame? □ yes □ no
If not, please describe: _____
_____

What do you wish to accomplish in the initial session? _____
_____

What are your goals for therapy? _____
_____
_____

What else would be helpful to know that will help your child in treatment? _____
_____
_____
_____

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