CHILD AND ADOLESCENT HEALTH AND DEVELOPMENTAL QUESTIONNAIRE

Please answer all questions. Honest answers will allow the therapist to have a better understanding of your child and family. Feel free to ask questions if you need help.

Today's Date:_____

Identifying and Contact Information:

Child's name: _____ Age:_____ Date of Birth _____

How would you identify your child (race, culture, gender, sexual orientation, spirituality/religion):

_____

Form completed by: _____

Relationship to the child :

◯ *Birth Mother* ◯ *Birth Father* ◯ *Stepparent* ◯ *Adoptive Parent* ◯ *Foster Parent*

◯ *Guardianship* ◯ *Grandparent* ◯ *Other (Describe):*

Current custody of child (check all that apply):

Self: ☐ *Legal* ☐ *Physical* ☐ *Joint (if separated or divorced)*

County: ☐ *Legal* *If so, which county?* _____

*Have there been any changes in custody, visitation, or support, formally or informally**?***

◯ ***No*** ◯ ***Yes*** ***If yes, please describe:***

Is there someone who shouldn't have custody or visitation or access to records?

◯ **No** ◯ **Yes** **If yes, please describe:**

What do you think your child needs help with at this time?

Stressors:

Has your child experienced any of the following and what age was the child?

☐ Death of a parent ____ Age
☐ Death of a close friend or relative ____ Age
☐ Death of a pet ____ Age
☐ Parental separation or divorce ____ Age
☐ Accident or serious injury ____ Age
☐ Prolonged separation from parent (s) ____ Age
☐ New person in household ____ Age
☐ Recent move or change in school ____ Age
☐ Physical abuse ____ Age
☐ Sexual abuse ____ Age
☐ Emotional abuse ____ Age
☐ Witnessed violence towards family members ____ Age
☐ Other stressful or traumatic experiences ____ Age
☐ Legal issues ____ Age

Developmental History:

Were there any problems during the pregnancy or delivery? (Such as: medication, alcohol/drug or cigarette or alcohol use, early labor, high blood pressure, diabetes, accidents, cord around neck, blue appearance, lack of oxygen, intensive care)

As a baby, were there any:

☐ Feeding problems, colic, food allergies
☐ Problems forming a close relationship between mother and child
☐ Baby sleeping too much /too little

Please describe:

As a toddler or small child, were there any:

☐ Problems with activity level
☐ Absence or odd speech
☐ Problems relating to others
☐ Unusual repetitive behaviors

Please describe:

Developmental Milestones: (Check one for each)

	Normal Range	Early	On-Time	Late	Don't Know
Crawling	6-9 months				
Walk alone	11-15 months				
First Words & Sentences	8-18 months				
Toilet trained (Bladder)	2-3 years				
(Bowel)	2-3 years				

Were/are there problems with bed wetting or soiling?

Additional comments:

Chemical/Alcohol History:

Are there any chemical use issues for your child? **No** **Yes**

- ☐ Tobacco/nicotine
- ☐ Alcohol
- ☐ Cocaine/crack
- ☐ Heroin
- ☐ Methamphatamines
- ☐ Sleeping pills

If yes, check all that apply:

- ☐ Diet pills
- ☐ Speed
- ☐ LSD/acid/angel dust
- ☐ Marijuana
- ☐ Prescription medications
- ☐ Other

Past Mental Health History:

Has your child received any mental health services? **No** **Yes** **If yes, check all that apply:**

- ☐ Counseling
- ☐ Chemical dependency treatment
- ☐ Hospitalizations
- ☐ Residential

Has your child been on any psychiatric medications? **No** **Yes** **If yes, please describe:**

_____ Medications/Dosage _____Prescribing Physician
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_____ Medications/Dosage _____Prescribing Physician

Past Medical History:

Does your child take any other medications? ◯ **No** ◯ **Yes** **If yes, please describe:**

Name and address of physician or clinic:

Has your child ever had a problem with any of the following?

◯ **No** ◯ **Yes** **If yes, please describe:**

Medical _____

TBI/concussion _____

Vision/hearing _____

Suicide/self-injury _____

Eating disorders _____

Are there other blood relatives of your child who have any of the following problems?

◯ **No** ◯ **Yes** **If yes, please describe:**

Medical _____

Mental health_____

Chemical dependency _____

Does your child have any allergies? ◯ **No** ◯ **Yes** **If yes, please describe:**

Preschool/Daycare/School History: ☐ ***NA***

Are there any concerns? ◯ **No** ◯ **Yes** **If yes, please describe:**

When were they first noticed?

Describe any special education services your child may be receiving: (For example EBD, IEP, 504 plan, math, reading, speech, accelerated/gifted)?