Date: / /

New Patient Information

Child's Name: _____ Sex: _____ Birthdate: _____ Age: _____

Questionnaire filled out by: ☐ Father ☐ Mother ☐ Both ☐ Other:_____

Presenting Problems:

What are your concerns regarding your child at this time?

In addition to the concerns expressed above, please check each symptom below that applies to your child and rate each symptom checked with a measurement of severity.
(Scale of 1 to 10: 1 = minimally problematic, 10 = extremely problematic)

Rating

☐ _____ Disturbing thoughts (Specify types of thoughts)

☐ _____ Fears/fearfulness (Specify types of fears)

☐ _____ Sleep difficulties (☐ Getting to sleep ☐ Waking up ☐ Low energy)

☐ _____ Stress (Specify)

☐ _____ School/work problems (Specify either or both)

☐ _____ Family problems (Specify type and individuals involved)

☐ _____ Anger problems, oppositional and/or defiant behaviors (Specify home, school or both)

☐ _____ Violence (Specify type and toward whom)

☐ _____ Legal problems (Specify type)

☐ _____ Other (Specify)

Developmental History for Children & Adolescents:

Pregnancy: ☐ Normal ☐ Illnesses ☐ Meds ☐ Bleeding ☐ Other: _____

Birth: ☐ Full term ☐ Premature ☐ C-section ☐ Complications

Ages of: Supporting head: _____ Rolling over: _____ Sitting: _____ Crawling: _____
Walking: _____ First word: _____ Feeding self: _____ Toilet training: _____

Trauma: ☐ Separation ☐ Divorce ☐ Death ☐ Surgeries ☐ Illnesses

Adjustment Problems: ☐ Crying ☐ Stuttering ☐ Thumb sucking ☐ Nail biting
☐ Bedwetting ☐ Nightmares ☐ Excessive fears ☐ Tantrums ☐ Cruelty
☐ Jealousy ☐ Hyperactive ☐ Stealing ☐ Lying ☐ Shy
☐ Dependent ☐ Low self-confidence ☐ Mood swings ☐ Other: _____

Social Development:

How many friends does your child have?

How would you describe your child?

☐ Passive / Assertive ☐ ☐ Dependent / Independent ☐
☐ Calm / Anxious ☐ ☐ Happy / Sad-Depressed ☐
☐ Trusting / Suspicious ☐ ☐ Sensitive / Calloused ☐
☐ Conforming / Rebellious ☐ ☐ Thoughtful / Impulsive ☐
☐ Inferiority / Self-Assured ☐ ☐ Serious / Carefree ☐
☐ Conventional / Risk-taking ☐ ☐ Shy / Outgoing ☐
☐ Demanding / Adaptable ☐ ☐ Selfish / Considerate ☐
☐ Detached / Warm ☐

Mental Health History: ☐ None

Has your child received counseling in the past? ☐ Yes ☐ No
If yes, when, with whom and for what reason?

Has your child been hospitalized for a mental health issue? ☐ Yes ☐ No
If yes, when and for what reason?

Is there a family history of mental health problems or nervous problems? ☐ Yes ☐ No
If yes, please explain.

Medical History:

Who is your child's Primary Care Physician? _____ Date of last visit:_____

Describe any present or past health concerns/problems, including any traumas or surgeries.

List all medications and dosages your child is currently taking.

Height: _____ Weight: _____ Recent weight gain or loss: _____ lbs. Appetite: _____

Substance Use/Abuse History:

	None	Past	Present	Frequency/Amount
Alcohol	☐	☐	☐	_____
Drugs	☐	☐	☐	_____
Nicotine	☐	☐	☐	_____
Caffeine	☐	☐	☐	_____

Has your child received treatment for any of the above substances? ☐ Yes ☐ No
If yes, when, for what substance and for how long?

Are there any family members with substance abuse problems? ☐ Yes ☐ No
If yes, list relationship and substance abused.

Family History:

Parent's marital status: ☐ Married ☐ Separated ☐ Divorced (# of times: _____)
If married, how would you describe the quality/satisfaction of your marriage?

If divorced, describe the custody arrangements.

Describe your relationship as parents (and step-parents if applicable) with your child.

Father:

Mother:

Step-parent:

Sibling's names: Age:

_____ M / F _____

_____ M / F _____

_____ M / F _____

_____ M / F _____

_____ M / F _____

Describe your child's relationship with his/her siblings.

Is there any history of verbal, physical, or sexual abuse for your child? ☐ Yes ☐ No
If yes, please describe.

Educational/Employment History:

Child's current grade: _____ School: _____

Describe any learning disabilities/difficulties for your child.

Describe any behavioral/discipline problems.

Describe your child's relationship with peers.

If employed, what job does your child hold and for how long?

Legal History:

Number of arrests: _____ Number of substance-related arrests: _____

Number of OUIL, DUIL, or DWI arrests: _____

Nature of other arrests:

Other legal concerns:

Religious/Spiritual Background:

List any formal religious affiliation.

Please describe your child's involvement.