

CEDAR CREEK ASSOCIATES
Private, Independent Practitioners

CHILD QUESTIONNAIRE

PERSONAL INFORMATION:

Name: _____

Date: _____

Date of Birth: _____

Age: _____

Please list any person living in the child's home:

Name	Age	Relationship	Quality of Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list other immediate family members not currently living in the child's home:

Name	Age	Relationship	Quality of Relationship
_____	_____	_____	_____
_____	_____	_____	_____

Mother's occupation: _____

Father's occupation: _____

Approximate family income: _____

Family's religion: _____

If the child was adopted, at what age? _____

Does the child know he/she was adopted? _____

Age when told about the adoption? _____

Has the child had any contact with the biological

parents since the adoption? _____

Does the child mention the biological parents? _____

EDUCATIONAL INFORMATION:

School: _____

Grade: _____

Does the child seem to like his or her teacher? _____

Has the child ever failed a

grade or been held back? _____ If so, please explain: _____

Has the child ever received special education, special resource, or speech services? _____ Explain:

MEDICAL INFORMATION:

Physician: _____

Date of last physical exam: _____

Please list any illnesses or medical conditions: _____

List any medication to which the child is allergic: _____

Please list any medications the child takes:

Medication	Amount of Dose	Frequency	Purpose of Medication
_____	_____	_____	_____
_____	_____	_____	_____

Please check and explain any concerns or events from the list below:

- _____ The child's weight or diet: _____
- _____ Has the child ever been unconscious from a head injury? _____
- _____ Has the child ever been neglected, traumatized, or abused? _____
- _____ Has the child had previous counseling or testing? _____
- _____ Has the child ever been hospitalized? _____
- _____ Has the child tried or used drugs, tobacco, or alcohol? _____
- _____ Does the child drink caffeine (soda, tea, coffee) and how much? _____

Has any person in the child's biological family ever:

- _____ Had depression? _____ Had a problem with alcohol or drug abuse?
- _____ Had schizophrenia? _____ Had bipolar or manic-depressive disorder?
- _____ Committed suicide? _____ Been imprisoned for a felony?
- _____ Had an anxiety disorder? _____ Had a learning disability or ADHD?
- _____ Been hospitalized for a psychiatric illness?

Has the child ever been the victim of a crime? If so, please explain:

SOCIAL/RECREATIONAL INFORMATION:

Please list the child's hobbies and interests: _____

How well does the child get along with peers? _____

Does the child have a best friend? _____ Does the child have a TV in the bedroom? _____

Estimate the number of hours per week the child watches TV: _____ Estimate the number of hours per week the child plays video or computer games: _____ Does the child have access to

the internet? _____ Do you restrict access to the internet, games and/or movies with violent or sexual content? _____

PRESENTING PROBLEM:

Please explain why you are seeking treatment for your child: _____

How severe are these concerns to you? _____ Mild _____ Severe _____ Extremely severe

How severe are these concerns to the child: _____ Mild _____ Severe _____ Extremely severe

When did the problem(s) begin? _____

What have you done to try and solve the problems? _____

Please check any symptoms your child is having:

- | | | |
|--------------------------------------------------|---------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Tiredness | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Increased tears |
| <input type="checkbox"/> Argues a lot | <input type="checkbox"/> Loss of interest in activities | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Withdrawal from others | <input type="checkbox"/> Clinging |
| <input type="checkbox"/> Worries a lot | <input type="checkbox"/> Changed eating habits | <input type="checkbox"/> Destructive |
| <input type="checkbox"/> Refuses to go to school | <input type="checkbox"/> Hurts self or talks about it | <input type="checkbox"/> Poor attention |
| <input type="checkbox"/> Aggressive behavior | <input type="checkbox"/> Hurts others or talks about it | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Soils or wets self | <input type="checkbox"/> Grades have dropped | <input type="checkbox"/> Over sleeps |
| <input type="checkbox"/> Rude to parents | <input type="checkbox"/> Won't follow instructions | <input type="checkbox"/> disobedient |
| <input type="checkbox"/> Strange ideas: _____ | | |
| <input type="checkbox"/> Other: _____ | | |

Please check any recent changes the child has experience:

- | | | |
|------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Illness or injury | <input type="checkbox"/> Family moved | <input type="checkbox"/> Friend moved |
| <input type="checkbox"/> Sibling left home | <input type="checkbox"/> New family member | <input type="checkbox"/> Parent left home |
| <input type="checkbox"/> Loved one died | <input type="checkbox"/> Experienced or witnessed violence | <input type="checkbox"/> Parents divorced |
| <input type="checkbox"/> Child moved into/away from family | | |
| <input type="checkbox"/> Other major loss or event: _____ | | |
| <input type="checkbox"/> Other: _____ | | |

I give permission to _____ to treat my child _____

in psychotherapy. I am the custodial parent or legal guardian of the child and I have the legal authority to authorize treatment.

_____ Without the consent of anyone else.

_____ Only with the consent of

Name

Address (number and street)

City, State, and Zip Code

Phone Number

_____ I agree to provide any necessary documentation.

I understand that no child custody evaluation will be performed and that therefore my therapist will not formulate an opinion regarding any custody issues, and that requiring the therapist to testify regarding custody issues would be harmful to my child and the therapeutic relationship.

Printed name of parent or guardian

Relationship to child

Signature of parent or guardian

Date

Thank you for selecting me as your child's therapist. Please feel free to discuss any concerns you may have about your child's treatment. At any time that I am alone with your child, you are invited to open the door and check on your child's well-being. The ending of therapy is as important to children as what takes place within it and I request that you talk with me about how therapy will terminate before we actually end.
