Shoudt & Reilly Psychological Services, LLC.

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CLIENT INFORMATION QUESTIONNAIRE

(ALL INFORMATION CONFIDENTIAL)

General Information Date: ___________________________

Child's Name:____________________________ Age:______ Sex: _______DOB:_______________

Address:___________________________________ City: ___________________ Zip:____________

Child's Legal Custodian: ________________________________ Home Phone:_________________

Name of person completing this form: ____

Relationship to child: ____

Referred by: ______________________________ Phone:____________________________________

Father's Name: _________________________Relationship if not biological: __________________

Mother's Name: ________________________ Relationship if not biological: _________________

Biological father's address (if not living with child):

____

Phone Number: ________________________ Frequency of Contact:__________________________

Biological mother's address (if not living with child):

____

Phone Number: ________________________ Frequency of Contact:__________________________

Please list name & address of your child's primary care physician & any other physicians involved in their care:____

____

____

List family members & all others in the home:

Name:	Age	Relationship	Occupation

Describe how you feel your child relates to the rest of the family:

If parents are divorced/separated, how old was the child at the time of separation?

List any other siblings (along with age & relationship) not in the home:

Please describe your child's current medical, behaviors and emotional problems. Include age at which problems started and any recent stressors:

What seems to help?

____
____
____
____

Circle any of the following if they have been problems for your child:

Speech or language	Fearful	Slow learner
Coordination	Wets bed	Sad
Prefers to be alone	Bites nails	Stomach troubles
Fights w/ siblings	Sucks thumb	Angry
Fights w/ peers	Tantrums	Can’t relax
Fights w/ adults	Nightmares	Lonely
Physically aggressive	Sleep	Feels inferior
Destroys property	Rocking	Suicidal Thoughts
Cruel to animals	Head banging	Trouble w/ friends
Steals	Holds breathe	Indecisive
Shy/timid	Poor appetite	Depressed
Reckless behaviors	Stubborn/willful	Nervous
Self injury	Overactive	Bowel Problems
Odd habits/mannerisms	Impulsive	Obsessive
Lack of friends	Frequent visits to nurse	Frequent visits to Guidance office

Developmental History:

Age of mother during pregnancy ________________ Mother's health: * good *fair * poor

List medications during pregnancy ____

Did mother smoke, drink alcohol or use substances during pregnancy? ____________________________

Specify amounts, types and frequency ____

____

Any illness during or complications of pregnancy?____

Length of pregnancy _________________weeks Labor ____________________hours

Birth Weight ____________ Type of Delivery *Vaginal *C-section

Any instruments/forceps? (Specify) ____

Any complications of delivery or birth defects? ____

Was the mother depressed or down after delivery? ____

Please describe child as an infant: *pleasant *fussy *calm *colicky *irritable *hard to manage

Any problems with sleep or feeding (describe) ____

____

Developmental Milestones:

To the best of your recollection, please fill in the age at which your child began each of these behaviors:

(If you cannot remember ages, specify if the event was early, on time, or late)

Showed response to parent ______________________

Rolled over ___________________

Sat alone _____________________

Crawled ______________________

Walked alone _________________

Babbled _____________________

Spoke single words ____________

Put several words together ______________

Dressed self _________________________

Toilet trained: Bladder _____ Bowel _____

Dry at night _________________________

Fed self ____________________________

Rode tricycle ________________________

Have there been any caregivers other than parents prior to kindergarten?

Age Setting Child's reactions/behavior

____

____

____

Medical History:

Please circle any of the following conditions your child has had & list age of occurrence

Measles	______________	Whooping Cough	______________
German measles	______________	Meningitis	______________
Mumps	______________	Encephalitis	______________
Chicken pox	______________	Seizures	______________
Rheumatic fever	______________	Head injury	______________
Broken bones	______________	Diabetes	______________
Visual problems	______________	Cancer	______________
Hearing problems	______________	Bleeding problems	______________
Paralysis	______________	Frequent nosebleeds	______________
Severe/frequent headaches	__________	Skin conditions	______________
Extreme fatigue	______________	Suicide attempt	______________
Anemia	______________	Bowel problems	______________
Memory problems	______________	Eating problems	______________
Tuberculosis	______________	Loss of consciousness	______________
Fever above 105	______________	Dizziness/fainting	______________

Is your child on a special diet? *No *Yes
Describe____

Does your child take any medications currently? * No *Yes

Please include any over the counter medications, herbal supplements or remedies.

Drug Dose Frequency Duration Reason Prescribed by

____
____
____
____

In the past, has your child ever been on medication for anxiety, depression, behavior problems, etc.?

Drug Dose Frequency Effectiveness Side Effects Why discontinued

____
____
____

Does your child have any drug allergies or sensitivities? *No *Yes

Drug Symptoms

____

____

Does your child have any other allergies or sensitivities (environmental, food, dye, latex, etc.)?

*No *Yes, describe ____

Caffeine consumption: (soda, tea, iced tea, coffee, etc.) amount _____________ per day/week

Sexual Development:

Has your child started developing sexual characteristics such as pubic hair or breast change?

*No *Yes If yes, at what age & what was your child's attitude toward this?

____
____

If applicable, age at first menstruation: ____________

Any menstrual irregularities, cramps or other physical discomfort? *No *Yes

Psychiatric History:

Has your child ever received any mental health and/or substance abuse treatment?

*No *In-patient *Out-patient

Place/Provider Dates Reason Outcome

____

____

____

When was your child last seen by a mental health professional? ________________________________

Significant Events – please circle & describe:

Event	Date	Describe
Loss of someone close	______________________	______________________
Loss of pet	______________________	______________________
Trouble with the law	______________________	______________________
Living/placement away from home	______________________	______________________
Incest/sexual abuse	______________________	______________________
Physical abuse or neglect	______________________	______________________
Emotional abuse	______________________	______________________
Held back in school	______________________	______________________
Moves	______________________	______________________
Significant health problems of self or family member	______________________	______________________

Child's Education

Grade ________________

Name and address of school child presently attends:

____ Phone: _________________________________

____

Please check what you feel describes your child in the following areas:

Attendance: Rarely absent Sometimes absent Often absent

Ability: Above average Average Below average

Relationship with peers: Above average Average Below Average

Behavior: Above average Average Below average

Has your child ever been suspended or expelled? *No *Yes

If yes, describe ____

Any difficulty with: * Reading *Math *Spelling *Writing *Other____________________

What, if any, special services have been provided for your child in school (speech/language, remedial reading, special classes, counseling, groups, occupational therapy)?

____

____

____

Does your child have an IEP? *No * Yes

Any school refusal or avoidance? *No *Yes

Social/Extracurricular activities (list & comment):

____

____

____

____

Family History:

Is there a family history of any of the following disorders – if so, please check and list family members on adjacent line:

Depression____

Manic-Depression ____

Anxiety Disorders____

Suicide Attempt ____

Autism ____

Attention Deficit/Hyperactivity____

Tics ____

Learning Disorders ____

Mental Retardation ____

Alcoholism ____

Drug Abuse ____

Any family history of medical problems, including diabetes, heart disease, cancer, seizures, Alzheimer's, asthma, etc.? * No *Yes

Describe

____

____

Parents' current marital status:

*Married & living together * Separated *Widowed * Mother remarried

*Single, never married *Divorced * Living together *Father remarried

How would you describe the relationship between you and your child's co-parent?

*No difficulties *Occasional difficulties *Frequent difficulties

Describe significant marital problems and how both spouses view them:

Mother's View:

____

____

Father's View:

____

____

Any marital counseling? *No *Yes

Parent's History:

Biological Mother:

Name: ____________________________ Age: ___________________________

Highest Level of Education: ____

Please describe any problems growing up – particularly those involving relationships/family:

____

____

____

Biological Father:

Name: ____________________________ Age: ___________________________

Highest Level of Education: ____

Please describe any problems growing up – particularly those involving relationships/family:

____

____

____

Adoptive or Stepmother:

Name: ________________________________ Age: ________________________________

Occupation: ____________________________ Highest Level of Education: _______________

Please describe any problems growing up – particularly those involving relationships/family:

____

____

____

How did this child adjust to his/her stepmother?

____

____

____

Adoptive or Stepfather:

Name: _______________________________ Age: ________________________________

Occupation: __________________________ Highest Level of Education: _____________

Please describe any problems growing up – particularly those involving relationships/family:

____

____

____

How did this child adjust to his/her stepfather?

____

____

____

Optional:

Some managed care companies require we ask the following questions regarding cultural/spiritual issues. You may choose to respond or not respond.

With what ethnic/cultural /racial group do you identify?____

What is your religious affiliation?____

What role does your religion/spirituality play in your life? ____
____

Are there any spiritual or cultural issues that you feel need to be taken into account in your child's treatment?
No Yes, Please explain ____
____

Please list any additional comments or concerns:
____
____
____
____
____
____
____
____