Shoudt & Reilly Psychological Services, LLC.

6720 E. Perkiomen Avenue, Birdsboro, PA 19508
Telephone #: 610-404-1726
Fax #: 610-404-1734
ShoudtReillyPsychologicalServices.com

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 child at 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 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 _____________________ Put several words together _____________

Rolled over __________________ Dressed self ________________________

Sat alone ______________________

Crawled _______________________

Walked alone __________________

Babbled ______________________

Spoke single words _____________

Toilet trained: Bladder _____ Bowel _____

Dry at night __________________________

Fed self _____________________________

Rode tricycle _________________________

Have there been any caregivers other than parent 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 _______________

German measles _______________

Mumps _______________

Chicken pox _______________

Rheumatic fever _______________

Broken bones _______________

Visual problems _______________

Hearing problems _______________

Paralysis _______________

Severe/frequent headaches ___________

Extreme fatigue _______________

Whooping Cough _______________

Meningitis _______________

Encephalitis _______________

Seizures _______________

Head injury _______________

Diabetes _______________

Cancer _______________

Bleeding problems _______________

Frequent nosebleeds _______________

Skin conditions _______________

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 check & 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:
____
____ Contact person:
____

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:
____
____
____
____
____
____
____
____
____