PREVAIL COUNSELING GROUP, PLLC
CHILD AND ADOLESCENT HEALTH AND DEVELOPMENTAL QUESTIONNAIRE

"Please answer all the 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 assistance."

Today's Date:_____ Child's Name: _____

Child's Address: _____
(Street Address) (City, State, Zip Code)

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

Child's Gender: Male [ ] or Female [ ] Child's Social Security Number: _____

Home Phone: _____ May we leave a message? [ ] Yes or [ ] No

Work Phone: _____ May we leave a message? [ ] Yes or [ ] No

Cell Phone: _____ May we leave a message? [ ] Yes or [ ] No

Who referred you to Prevail Counseling Group ? _____

Race: [ ] African/American [ ] Asian [ ] Hispanic [ ] Native/American [ ] Caucasian [ ] Other

Are there ethnic/cultural/lifestyle/gender/religious considerations you would like us to be aware of during your care?
[ ] Yes or [ ] No

If yes, please describe: _____
_____

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

Are there any legal or custody issues, including who has legal custody, physical custody? Please explain: _____
_____
_____
_____

Section 1 – Developmental History

Were there any problems during pregnancy or delivery? (Such as medications, alcohol/drug or cigarette 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 or too little

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 any issues marked above: _____
_____
_____
_____

Section 2 – Developmental Milestones

Please check the most appropriate box regarding your child's developmental activity.

Activity	Normal Range	Early	On Time	Late	Don't Know
Crawling	3-6 Months				
Walk Alone	11-15 Months				
First Words & Sentences	8-18 Months				
Toilet Trained (Bladder)	2-3 Years				
Toilet Trained (Bowel)	**2-3 Years**				

Were/are there any problems with bed wetting or soiling? _____
_____

Section 3 – Chemical / Alcohol History

Are there any chemical use issues for your adolescent? [ ] Yes or [ ] No If yes, check all that apply below.

_____ Tobacco Use
_____ Alcohol
_____ Cocaine/Crack
_____ Heroin
_____ Sleeping Pills
_____ Diet Pills
_____ LSD/Acid/Angel Dust
_____ Marijunana
_____ Methamphetamine
_____ Other

Do you think anyone else in your family has a chemical / alcohol use / addiction problem? Please explain: _____
_____
_____

Section 4 – Current / Previous Mental Health Services

Name of current Psychiatrist or Clinic: _____

Name of County Social Worker: _____

- Name of Prior Psychiatrist: _____ Years Treated: _____

  Medications: _____

- Name of Prior Therapist: _____ Years Treated: _____

  Issues: _____

- Most recent psychiatric hospitalization: _____ Hospital Name: _____

  Approximate number of psychiatric hospitalizations: _____

If members of your family have been treated for a mental illness, please indicate relationship to child and diagnosis: ____
_____
_____
_____
_____

Section 5 – Medical History

Child's Primary Care Physician and / or clinic name: _____

Address of Physician and / or clinic name: _____

Please list all prescription and over the counter medications your child takes on a regular basis: _____
_____
_____

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

____ Allergies to Medications	____ Other Allergies	____ Asthma
____ Diabetes	____ Vision Problems	____ Heart Murmur or Heart Problems
____ Hearing Loss	____ Seizures (staring spells)	____ Head Injury, Concussion, Knocked Out
____ Surgery (What Kind)	____ Anorexia	____ Bulimia
____ Suicide Thoughts or Attempts	____ Self Injury	____ Other

Please explain: _____
_____
_____
_____
_____

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

____ Depression	____ Learning Disabilities	____ Suicide Thoughts or Attempts
____ Thyroid Disease	____ Bipolar	____ Heart Disease
____ Eating Disorder	____ Seizures Disorder	____ Schizophrenia
____ ADHD	____ Anxiety Disorder	____ Other

Section 6 – Preschool / Daycare History

Did or does your child attend preschool or daycare? [ ] Yes or [ ] No

Were or are there any problems with his or her behavior? [ ] Yes or [ ] No

Please describe any of those problems or behaviors: _____
_____
_____
_____
_____
_____

Did your child have problems separating from parent(s) for more than the first few days? [ ] Yes or [ ] No

Please describe any of those problems or behaviors: _____
_____
_____
_____
_____
_____

Section 7 – School History

Name of Child's School: _____ Grade Level: _____

Are there any behavior or academic concerns for your child? [ ] Yes or [ ] No

Please explain those behavior or academic concerns: _____
_____
_____

When were these problems **first** noticed by parent(s) or school? _____

Check problems that apply to your child:

____ Fighting ____ Stealing ____ Arguing with Teachers ____ Refusing to Do School Work

____ In School Suspension, Suspended or Expelled ____ Police or Court Involvement because of Behavior Problems

____ Truancy, Unexcused Absences, Skipping – If Yes, How much school has your child missed? _____

Is your child receiving special educations services? [ ] Yes or [ ] No Accelerated/Gifted Services? [ ] Yes or [ ] No

Please explain: _____
_____
_____

Section 9 – Peer Relationships

Please answer the following regarding your child:

____ Is shy or timid ____ Is bossy or controlling ____ Gets upset if she or he doesn't get her or his own way

____ Has many friends ____ Has few friends ____ Has no friends

Any other relationship issues you are concerned about with your child? _____
_____

Is your child old enough to be employed? [ ] Yes or [ ] No

If yes, what is his or her experience: _____
_____

Section 10 - Stressors

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

____ Death of 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 Experience	____ Age		