Lake-Cook Behavioral Health Resources
Child/Adolescent Health History Questionnaire

Form Completed By: _____ Relationship: _____ Date: _____

Child/Adolescent Information:

Full Name: _____ Nickname: _____ Date of Birth: _____

Mother Information:

Full Name: _____ Date of Birth: _____
Occupation: _____

Father Information:

Full Name: _____ Date of Birth: _____
Occupation: _____

Mother and Father are married: _____Yes _____No If No, describe status: _____unmarried
_____separated
_____divorced
_____other

Is there a finalized legal document regarding legal and physical custody of the child? _____Yes ____No
If no, is such a document pending? Please explain: _____

_____

If the parents are divorced, do both parents know about and agree to the child's participation in therapy?
___Yes ___No

If applicable, do both parents know and agree to the child's participation in seeing a Psychiatrist?
____ Yes ____No

Concerns:

1. What main concerns do you have about your child? What made you decide to come in now?

_____

_____

_____

2. What are some examples of behavior that you are concerned about? _____

_____

3. When did the problems/concerns begin? _____

4. How would you like things to be different? _____

_____

5. What steps have you already taken to address these issues? _____

_____

_____

Check Behaviors that apply to your child/adolescent now:

____Argues	____Physical Aggression	____ easily annoyed	____Steals
____Rebellious	____Cruel to Animals	____ Destroys Property	____Lies
____Lights Fires	____Easily Frustrated	____Overreacts	____Tense
____Misses School	____Physical Complaints	____Worries	____Fearful
____Temper Tantrums	____Defies Requests	____Blames others	____Fidgets
____Vindictive	____Distractible	____Dislikes Homework	____Forgetful
____Impulsive	____Short Attention Span	____Cries easily	____Sad
____Withdrawn	____Suicidal Thoughts	____Suicide Attempts	____Moody
____Motor or Vocal Tics	____Sleep Problems	____Apathy	____Self-harming Behaviors

____Odd or Peculiar Behaviors (please describe):_____
____Other (please describe):_____

If your child has ever been physically or sexually abused, please describe: _____

_____

Has your child had any contact with the police? ____Yes ____No If yes, please describe circumstances:_____

_____

Family History

Siblings (names & ages):_____

Who lives in the home now? _____

Are there any other mental health issues in the family? ____ Yes ____ No If yes, please describe:_____

_____

_____

Developmental History

Were there any problems during the pregnancy? ____ Yes ____No if yes, please describe: _____

_____

Was there any use of drugs or alcohol during the pregnancy? ____ Yes ____ No

Were there any complications before, during or immediately after delivery? _____

_____

_____

Did any of the following conditions affect your child during delivery or within the first few days after birth?

Injured during delivery ____Yes ____ No
Delivered with cord around neck ____Yes ____No
Was cyanotic, turned blue ____Yes ____No
Had an infection ____ Yes ____No
Was given medications ____Yes ____No
Was in the hospital more than 7 days ____ Yes ___No
Cardiopulmonary distress ____ Yes ____No
Had trouble breathing following delivery ____Yes ____No
Was Jaundiced, turned Yellow ____Yes ____No
Had seizures ____Yes ____No
Born with congenital defect ____Yes ____No

At what age did your child do the following?

Walk alone: _____
Complete toilet training _____
Speak single word _____
Dress themselves: _____
Stop wetting the bed _____
Speak Phrases _____

Are there any other developmental concerns/issues you would like us to know about? _____

_____

_____

Does your child have any allergies (environmental, food, medication)? ____Yes ____ No If yes please list:

_____

Does your child take any medications? (include vitamins, over the counter drugs, and herbal medicine)
____ Yes ____ No

If yes, list current medications, dosage, and frequency:

Medication/Vitamin	Dosage	Frequency	Date Began
1.			
2.			
3.			
4.			

Has your child been hospitalized for any reason? ____Yes ____ No If yes, please specify_____

_____

School & Social History

Has your child's pre-school/school had any concerns regarding your child? ____ Yes ____No if yes, please describe: _____

_____

Are there any areas in school that your child is struggling? ___Yes ___No if Yes please describe and when 1st noticed problem: _____

_____

Are there other professionals involved with your child (school counselor, social workers, foster parents or pediatrician)?

_____

Does your child have an Individualized Education Plan (IEP) ____ Yes ____ No If yes, what special needs and what services does your child receive? _____

_____

Describe your child's friendships:_____

_____

Does your child have any shyness or difficulties interacting with adults? ____Yes ____No

What activities hold your child's interest the longest? _____

Is play active or very quiet? _____

Is your child observant? _____ Is your child distractible? _____

Are there any stresses facing your child at this time? ____ Yes ____No If yes, please tell us more:_____

_____

_____

Is there any other information that might assist us in understanding your child? _____

_____

_____

I, the legal parent/guardian of the child or adolescent agree that the information provided on this form is correct to the best of my knowledge.

_____ _____

Signature of Parent/Guardian Date