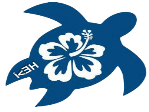


Living Life Counseling Center
Child Questionnaire

Patient Name: ______________________________Age_______ DOB: ___________ Date: ________

Telephone no: (Home) _________________ (Work) ________________ (Cell) __________________

Legal Guardian Name: __________________________________Relationship to Patient: ___________

Emergency Contact Information: Name: ______________________________

Relationship________________________ Telephone No: ____________________

Home Phone #: _________________________Work Phone #: _____________________________

Please state in your own words why you have come to today:

____

____

____

____

Please check ALL of the following symptoms or thoughts that apply to you **AT THIS TIME** **or during the past six months:**

Depressed mood
Diminished interests or pleasure
Sleep disturbance
Fatigue
Change in appetite
Hopelessness
Pleasure in few activities
Weight change Agitation
Excessive worry
I feel like I am losing control.
Irritability
Poor Concentration
Tension
Feelings of panic
Socially withdrawn
Use of alcohol
Use of other drugs
Use of tobacco
Anxiety in social settings
Makes careless mistakes
Does not complete tasks
Difficulty organizing
Forgetful
Confusion
Disorientation

Compulsive checking / counting
Indecisiveness
People talk about me.
Some people want to hurt me.
I feel emotionally distant from others.
I hear voices or sounds others do not hear.
I see things others do not see.
I smell things others do not smell.
Racing thoughts
I do risky or dangerous things.
Little interest in sexual activity
Sexual problems
Gender concerns
I don't like my body.
Binge eating
Self-induced vomiting
Laxative abuse
Excessive fasting
Intense fear of weight gain
Impulsive Behavior
I think about hurting myself.
I have tried to hurt myself.
Sometimes I wish I were dead.
I think about hurting someone else.
Exposed to a significant traumatic event
Recurrent distressing dreams

History of Present Illness: (*How long has this particular issue been going on*):

____
____
____
____

Sleep Disturbance Yes □ No □ (if yes please describe)

____
____
____

Appetite Changes Yes □ No □ (if yes please describe)

____
____
____
____

Psychiatric History:

I have received treatment for: Substance abuse □ Mental health issues □ Both □

The treatment occurred at:

□ Other private psychiatrist □ Mental Health Center
□ Hospital □ Other counseling service □ Other facility

If hospitalized, please list dates and where hospitalized________________________________
____
____

Are you presently being treated? Yes □ No □ If yes, by whom? _______________________

Are you currently being prescribed psychiatric medications? Yes □ No □

If Yes, please list **Current Psychiatric** medications___________________________________
____

Psychological Testing:

Have you ever had psychological testing done in the past? □ Yes □ No

If yes, When_______________________ and by Whom____________________________

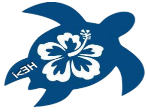
Medical History:

Name of your primary care doctor ____

Phone: _______________________________ Date last seen: ________________________

Do you have a history of any medical problem? Yes □ No □ If so, what? __________
____

Are you presently being treated for any medical problem? Yes □ No □ If so, what?
____



Living Life Counseling Center
Child Questionnaire

Please list any current **Non-Psychiatric Medications**________________________________

____

Have you ever been treated for a nutritional problem?	□ Yes	□ No
Do you make yourself sick because you feel uncomfortably full?	□ Yes	□ No
Do you worry you have lost control over how much you eat?	□ Yes	□ No
Have you recently lost more than 14 pounds in a 3 month period?	□ Yes	□ No
Do you believe yourself to be fat when others say you are too thin?	□ Yes	□ No
Would you say that food dominates your life?	□ Yes	□ No

Are you experiencing any physical pain? Yes ___ No ___

Family Psychiatric/Medical History: *(*Please list any familial psychiatric or major medical problems)

____
____
____

Social History*:* (Who does child live with, please state if parents are divorced and share custody also list any friends or outside supports)

____
____

Developmental History*:*

Your child's weight at birth: ______lbs. ______oz. Was this a full term birth? Yes □No □
If no, explain:

____
____

Did either parent use drugs or alcohol at the time of conception? Yes □ No □

Were there any complications with the labor & delivery such as jaundice, infection etc.? Yes □ No □
If yes, explain:

____
____

Did child meet all developmental milestones on time? Yes □ No □
If No please explain ____
____
____

Educational/Occupational

Current Grade: ______

Name school currently attending ____

Recent Report Card Grades _________________________

IEP/504 Yes □ No □ (if yes please explain why) ____
____
____

Behavioral Problems:
Has child ever had in or out of school suspension? Yes □ No □ (if yes please explain why)
____
____
____

Has child ever had problems with bullying? Yes □ No □ (if yes please explain)
____
____
____

Military Dependent: Yes □ No □

Spiritual/Religious Affiliation

Attends church Yes □ No □ If Yes where ____

History of Legal Problems No □Yes □ (if yes please explain:)
____
____
____

History of trauma*? (To include abuse, domestic violence, witnessing of; and military trauma)*:

No □ Yes □ (**If yes please explain**):
____
____
____

Thank you for your cooperation and patience. Our clinician will see you shortly and discuss these and other issues in greater detail and help you develop a treatment plan to effectively deal with these issues.