Lifestyle Insight Therapy, LLC

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Child History Questionnaire

Please provide the following information. Leave blank any question you would rather not answer, or would prefer to discuss with me. Information you provide here is confidential.

Today's Date:_____/_______/________ Client Name:________________________

Date of Birth:_____/_______/________ Age:________________________________

Preferred Name:______________________________

Mother's Name:______________________________ Mother's Age:________________________

Mother's Occupation:_________________________

Father's Name: Father's Age:

Father's Occupation:

Are parents married? ☐ No ☐ Yes

If no, please select- ☐ Unmarried ☐ Separated ☐ Divorced ☐ Other

Is the child adopted? ☐ No ☐ Yes

If yes, when was the child adopted? _______________________

What are the primary concerns that have brought you in today?

____

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____

____

Other children in the family (name/age/relationship to the child):

____

____

____

Additional persons living in the household (name/age/relationship to the child):

____

____

____

Medical History

Has your child received any type of mental health services in the past (therapy, psychiatric services, etc)?

☐ No ☐ Yes If yes, previous services/practitioner/date:________________________________

Is your child currently receiving any additional mental health services (therapy, psychiatric services, IEP, etc)?

☐ No ☐ Yes If yes, please describe:____

Is your child currently taking prescribed medication? ☐ No ☐ Yes
If yes, please list/dose:

____
____
____

Date of last physical exam:_____/_______/______ Name of Doctor:_________________________

Does your child have any allergies? ☐ No ☐ Yes
If yes, please list:

____
____
____

Has your child been hospitalized for any reason? ☐ No ☐ Yes
If yes, please describe:

____
____
____

Developmental History

Length of pregnancy:_________________________

Mother's age when child was born:___________

Did any of the following occur during pregnancy/delivery?

☐ Serious illness or injury ☐ Use of prescription drugs ☐ Toxemia/preeclampsia

☐ Use of alcoholic beverages ☐ Smoked cigarettes ☐ Bleeding

Did any of the following affect your child shortly after birth?

☐ Delivered with cord around neck ☐ Had seizures ☐ Had an infection

☐ Born with congenital defect ☐ Given medications ☐ Trouble breathing

Was your child late in achieving any of the following developmental milestones?

☐ Motor Skills (crawling/standing/walking/jumping): ☐ No ☐ Yes

☐ Speech and Language (babbling/first word/sentences): ☐ No ☐ Yes

☐ Self-Help (feeding/bowel movements/dressing): ☐ No ☐ Yes

☐ Social/Emotional (smiles responsively/plays alone/plays with others): ☐ No ☐ Yes

If you answered yes to any of the above, please describe:

____

____

____

School History

Does your child have an IEP? ☐ No ☐ Yes

If yes, please describe:

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Does your child take any special classes (special education, honors classes, etc)?

☐ No ☐ Yes

If yes, please describe:

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____

School your child currently attends/grade level:______________________

Are there any behavior problems at school? ☐ No ☐ Yes

If yes, please describe:

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____

Social Development

Does your child make friends easily? ☐ No ☐ Yes

Does your child have a "best friend"? ☐ No ☐ Yes

Does your child have social problems? ☐ Mild ☐ Moderate ☐ Severe ☐ None

Behavior Problems

Does your child currently engage in/or have a history of the following behaviors:

☐ Anger outbursts ☐ Lying ☐ Suicidal talk/gestures

☐ Cruelty to animals ☐ Argues a lot ☐ Skipping school

☐ Sexual behavior that is a concern ☐ Stealing ☐ Fire Setting

☐ Drug or Alcohol Use ☐ Running away ☐ Bad Language

If yes or other, please describe:

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____

____

Family Stressors

Has there been death of a family member or significant individual in the child's life?

☐ No ☐ Yes

If yes, please describe:

____

____

____

Has there been major illness of a parent or sibling? ☐ No ☐ Yes

If yes, please describe:

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____

Please list any moves and how your child adjusted:

____

____

____

Are there any other stressors facing the family or child at this time? ☐ No ☐ Yes
If yes, please describe:

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____
____

Family Mental Health History

Is there a family history of any of the following:

☐ Alcohol/Substance Use	☐ Anxiety	☐ Bipolar Disorder
☐ ADHD	☐ Suicide Attempts	☐ OCD
☐ Depression	☐ Eating Disorder	☐ Schizophrenia
☐ Autism Spectrum Disorder	☐ Obesity	☐ Learning Problems

If yes, please list which family member(s):

____
____
____

Psychological Testing

Has your child had any psychological testing? ☐ No ☐ Yes
If yes, please include date of testing and who performed it:

____

Is there any additional information that may assist in helping your child?

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____
____

What do you and your child hope to accomplish in our work together?

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