

To help us provide the best treatment for you, please answer the questions on this form and **return it to our clinic as soon as possible** to assist us with scheduling your first appointment

- You may also submit Online via Secured Email: BehavioralHealth@OnvidaHealth.org
- Faxing: 928-336-2490

CHILD AND ADOLESCENT PATIENT QUESTIONNAIRE

Who referred your child? _____

What was their concern? _____

What is your primary concern? _____

What is the school's primary concern? _____

When did you first become aware of concerns? _____

Name of Child: _____
First Middle Last

Street Address: _____

City _____ State/Zip _____

Phone # _____ Social Security # _____

Date of Birth _____ Place of Birth _____

Religion _____ National Heritage _____

Height _____ Weight _____ Eye Color _____ Hair Color _____

Who has legal custody or guardianship of child? _____

FAMILY DATA

FATHER:

Name _____ DOB _____

Address _____

Home Phone () _____ Work Phone () _____

Place of Employment _____ Title _____

Highest Level of Education _____ Religious Affiliation _____

MOTHER:

Name _____ DOB _____

Address _____

Home Phone () _____ Work Phone () _____

Place of Employment _____ Title _____

Highest Level of Education _____ Religious Affiliation _____

STEPMOTHER:

Name _____ DOB _____

Address _____

Home Phone () _____ Work Phone () _____

Place of Employment _____ Title _____

Highest Level of Education _____ Religious Affiliation _____

STEPPFATHER:

Name _____ DOB _____

Address _____

Home Phone () _____ Work Phone () _____

Place of Employment _____ Title _____

Highest Level of Education _____ Religious Affiliation _____

Please identify marital status including dates of all marriages, divorces and remarriages, for both natural and stepparents.

List on this page in chronological order the names of all children including the applicant, stepbrothers and sisters, half brothers and sisters, and any miscarriages or stillbirths. Also give a brief description of each child. (Birth date, school status, significant characteristics). Please state their relationship to applicant.

NAME	RELATIONSHIP TO YOUR CHILD	SEX	DOB	EDUCATION AND/OR OCCUPATION
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List other children or adults who have lived or are now living in the home and their relationship to the applicant.

List dates of moves and for what reasons.

How long at present address? _____

DEVELOPMENTAL INFORMATION

Length of Pregnancy _____ Birth Weight _____

Planned or unplanned pregnancy _____

Was the pregnancy complicated or involved with drugs or alcohol? _____

Nature of delivery: _____ Natural _____ Caesarian _____ Breech

Condition of child at time of birth _____

If child was adopted, from where? _____

At what age was child adopted? _____

Age of parent at time of birth or adoption: Father _____ Mother _____

Please give age your child: crawled _____, walked _____, talked _____, toilet trained _____

What have the significant stressors or traumas been to the family and child?

EDUCATION HISTORY

Where is child attending school now? _____

What grade? _____

If it is an ungraded class, state approximate grade achieved _____

If child is not enrolled, name last school attended, grade achieved, date withdrawn.

List in order of attendance, all school enrollments child has had; also names of tutors, if any. Give name and address. Indicate if it was a public or private school and the grade attended.

School	Address	Public/Private	Average Grade Made
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Have any grades been repeated? _____

Has the child been identified for special education, learning support or emotional support? Please state year identification and provisions made.

Please check those items that pertain to your child:

- _____ Often fails to finish things he or she starts
- _____ Easily distracted
- _____ Has difficulty concentrating
- _____ Shifts excessively from one activity to another
- _____ Frequently is disruptive in class
- _____ Has difficulty awaiting his/her turn (i.e. games)
- _____ Has difficulty sitting still.
- _____ Impulsive or acts without thinking

- _____ Abusive to animals
- _____ Physically violent towards property (i.e. vandalism, destructive)
- _____ Physically abusive to self (scratches self, suicidal attempts)
- _____ Firesetting
- _____ Stealing, Shoplifting, Breaking and Entering
- _____ Runaway
- _____ Lying
- _____ Chronic violation of parental limits
- _____ Drug Abuse (what kind?) _____
- _____ Alcohol Abuse (what kind?) _____
- _____ Any involvement with juvenile court
- _____ Unrealistic fears (Explain) _____
- _____ Acts too young for his/her age
- _____ Clings to adults or too dependent
- _____ Feels no one loves him/her
- _____ Gets teased a lot
- _____ Complains of loneliness
- _____ Demands a lot of attention
- _____ Easily made jealous
- _____ Refusal to attend school
- _____ Avoidance of being left alone
- _____ Excessive need for reassurance
- _____ Very self-conscious or easily embarrasses
- _____ Often appears tense and unable to relax
- _____ Frequent physical complaints (i.e. headaches, stomach aches, nausea)

- _____ Overly concerned with future events
- _____ Nervous mannerisms (i.e. nail biting, thumb sucking, rocking)
- _____ Feelings of inadequacy
- _____ Panic – feelings of intense fear/discomfort with palpitations, tremors, shortness of breath, choking feelings, etc.
- _____ Obsessions – unwanted ideas, images or impulses that intrude on thinking against your wishes and efforts to resist them. (Fear of contamination, recurring doubts about danger, extreme concern with order, symmetry or exactness).
- _____ Can't get his/her mind off certain thoughts
- _____ Fears he/she may do something bad
- _____ Fears she/he has to be perfect

- _____ Strange thoughts or ideas (Explain) _____
- _____ Hallucinations – visual or auditory-Describe _____
- _____ Inappropriate expression of feelings (i.e. laughing at something sad)
- _____ Concern that people are out to get him/her
- _____ Severe mood changes (i.e. very sad to very happy)
- _____ Often appears sad
- _____ Confused or seems to be in a fog
- _____ Day dreams or gets lost in his/her thoughts
- _____ Doesn't seem to have much energy
- _____ Social withdrawal
- _____ Overtired
- _____ Pessimistic outlook toward the future
- _____ Excessive tearfulness or crying
- _____ Recurrent thoughts about death or preoccupation with death
- _____ Suicidal thoughts or verbalized intentions
- _____ Concerns about sexual identity
- _____ Sexually promiscuous
- _____ Inappropriate sexual behavior (Explain) _____

- _____ Poor relationship with parents
- _____ Sibling rivalry
- _____ Negative peer associates-hangs with others that get in trouble
- _____ Argues a lot, bragging, boasting
- _____ Mean to others
- _____ Has difficulty making or keeping friends
- _____ Does not associate with people his or her own age
- _____ Avoids unfamiliar social situations
- _____ Is easily led by others
- _____ Has difficulty participating in organized activities (sports)
- _____ Avoids competitive situations

- _____ Sleep difficulties (i.e. sleepwalking, restless, inability to fall asleep or sleeps too much)
- _____ Eating difficulties (i.e. has difficulty keeping food down, overeats, does not have much of an appetite, fear of trying new foods, tremendous concern about weight).
- _____ Poor personal hygiene (does not keep self clean or take an interest in appearance)
- _____ Enuretic (urinates during the day or night on self)
- _____ Encopretic (soils self)
- _____ Deliberately harms self
- _____ Tics (sudden rapid, recurrent motor movements or vocalizations)
- _____ Behaves like the opposite sex

PSYCHIATRIC/PSYCHOLOGICAL/MEDICAL

List all doctors and mental health professionals who have examined and/or treated your child.
Please give name, address and phone number for each.

Family Physician _____

Dentist _____

Orthodontist _____

Psychiatrist/Psychologist/or Mental Health Facility _____

Medications your child has been on in the past for mood or behavior:

What medication(s) is your child taking now?

List any allergic reactions to medications:

List any allergies that your child may have and how it is treated.

If your child has ever been **hospitalized** please explain when and for what reason.

Name of Hospital

Date

Diagnosis

Has this child ever been exposed to abuse? Please state whether it is/was physical, emotional or sexual and whether he was the object to the abuse or exposed to it.

Please check if any of the following pertain to your child and explain (use back of page if necessary).

_____ Heart Disease

_____ Nausea or vomiting

_____ Concussions

_____ Lung Disease

_____ Drug or alcohol abuse

_____ Nervous disorders

_____ Liver Disease

_____ Diarrhea (frequently)

_____ Neurological testing

_____ Jaundice	_____ Diabetes	_____ High fevers
_____ Seizures	_____ Tonsillectomy	_____ Injuries or broken bones
_____ Fainting	_____ Orthodontia	_____ Accident prone
_____ Asthma	_____ Skin Disease	_____ Activity limitations
_____ Dietary problems	_____ Irregular Sleep Patterns	
_____ Hearing problems	_____ Visual problems	_____ Speech problems
_____ Urinary problems	_____ Bowel or elimination problems	_____ Other

GYNECOLOGY

_____ Pregnancy
 _____ Abortion (if so, when) _____
 _____ Miscarriage (if so, when) _____
 _____ Menstrual problems
 _____ Birth control (if so, what type) _____

FAMILY MEDICAL/PSYCHIATRIC HISTORY

Please check which, if any, of the following conditions/problems apply to your child's blood relatives. If other significant medical/psychiatric problems are present among blood relatives, please list those in the space provided below.

	Child's Mother	Child's Father	Child's Brother(s)	Child's Sister(s)	Child's Grandp(s)	Other
Childhood oppositional/defiant						
Problems with aggression						
Attentional problem						
Learning disability						
Failed high school						
Mental retardation						
Psychosis/schizophrenia						
Depression (greater than 2 weeks)						
Anxiety or adjustment disorder						
Panic disorder						
Other mental disorder (describe below)						
Tic disorder or Tourette's						
Alcohol Abuse						
Substance Abuse						
Antisocial behavior (assault/thefts)						
Arrests/incarcerations						
Physical abuse (victim)						
Physical abuse (perpetrator)						
Sexual abuse (victim)						
Sexual abuse (perpetrator)						

Name of person completing this form: _____

Relationship to applicant: _____

I do certify that all the foregoing information is true and complete.

NAME _____ DATE _____

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