# CLIENT QUESTIONNAIRE: MINOR

**A. Identifying Information**

1. Client (Child's Name): ____________________ Date of First Appt.: __________
   Address: ____________________
   DOB: __________ Age: __________ Ethnicity/Race: __________
   Predominant Language: __________ Language Spoken at home: __________
   Name of person(s) completing this form: __________ Relationship to Child: __________
   Today's date: __________

2. Parent's name: ____________________
   Address: ____________________ Home Phone: __________
   Currently employed: _____No _____Yes, as: __________ Work Phone: __________

3. Parent's name: ____________________
   Address: ____________________ Home Phone: __________
   Currently employed: _____No _____Yes, as: __________ Work Phone: __________

4. Child's custodian/guardian is: ____________________

5. Step-parent's name: ____________________
   Address: ____________________ Home Phone: __________
   Currently employed: _____No _____Yes, as: __________ Work Phone: __________

6. School your child attends: ____________________ Grade: __________
   How long has your child been at this school? __________
   Address: ____________________
   Teacher's name: ____________________ Phone: __________
   What type of classroom is your child currently in (regular ed., special ed., gifted program)? __________

7. Pediatrician's name: ____________________ Phone: __________
   Address: ____________________ Date of last visit: __________

**B. Clinical Information**

1. How did you hear about us? ____________________
   Name: __________ Phone: __________ Address: __________

2. Chief Concern

   Please indicate why you are currently seeking psychological services for your child:

   ____________________
   ____________________
   ____________________

3. Prior treatment

   Has your child ever received psychological/psychiatric services of counseling? ______ Yes ______ No
   If yes, please indicate reason, approximate dates, duration, and type of treatment, and results:

   ____________________
   ____________________
   ____________________
   ____________________

Has your child ever taken medications for psychiatric or emotional difficulties? ______ Yes ______ No
If yes, please indicate medications taken, when they were taken, and results:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Has your child ever been hospitalized for psychiatric reasons? ______ Yes ______ No
If yes, please indicate approximate dates and location(s): ________________________________________
________________________________________________________________________________
________________________________________________________________________________

4. Developmental History

Pregnancy and Delivery:
Biological child: _____ Yes _____ No If no, when adopted? Where? Process?__________________
________________________________________________________________________

Infancy (colic, sleep/eating patterns, child care): ________________________________________
________________________________________________________________________

Early Milestones: Sensory Sensitivities: ______________________________________________
________________________________________________________________________

Fine/Gross Motor: ________________________________________________________________

5. Family Psychiatric History

Please indicate any history of psychiatric or emotional difficulties among immediate or extended family members:
________________________________________________________________________________
________________________________________________________________________________

**C. Psychosocial Functioning**

1. School Functioning

Please list the schools your child has attended:

School Name and Address | Grades Attended
---|---
______________________________________________________ | _______________
______________________________________________________ | _______________
______________________________________________________ | _______________
______________________________________________________ | _______________

Has your child ever received a Child Study Team Evaluation or been tested for academic and/or behavioral concerns?
_____ No _____ Yes
If yes, please describe when and by whom: ________________________________________________
________________________________________________________________________________
(If the testing report is available, please attach a copy)

Has your child ever been placed or recommended for a special academic setting such as special education or a gifted program? _____ No _____ Yes, classification/program: ________________________________________

Has your child received ongoing support services within the school such as occupational therapy, speech therapy, or counseling? _____ No _____ Yes, services: ____________________________________________________

Please describe any academic services, outside of school, your child is receiving (for example tutoring or an afterschool program):

________________________________________________________________________________

________________________________________________________________________________

Has your child ever repeated a grade? ______ No _____ Yes, grade(s): ________________________

What do you feel are your child's academic strengths and difficulties?

________________________________________________________________________________

________________________________________________________________________________

Please indicate the grades your child obtained on his/her most recent report card (if available, please attach a copy of this report care):

________________________________________________________________________________

________________________________________________________________________________

How does your child's teacher describe his/her classroom behavior? ____________________________________

________________________________________________________________________________

________________________________________________________________________________

Please describe your child's overall attitude towards school: __________________________________________

________________________________________________________________________________

________________________________________________________________________________

2. Social Functioning

Please indicate who lives in your household at this time:

| Name | Age | Relationship to Child |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

How do you feel your child gets along with other members of his/her family? ______________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

How would you describe your child's interactions with others? (peers, adults, romantic, etc.)

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

What disciplinary methods do you employ/ how do you react when your child acts out?______________________
________________________________________________________________________________
________________________________________________________________________________

What are your child's primary interests? ______________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Has your child had any speech, hearing, or language difficulties? If so, please describe: ______________________
________________________________________________________________________________

Approximate date of last physical exam: _____________ Present height: __________ Present weight: _________

Please list any past or current prescription medications your child has taken/is taking (excluding psychiatric medication and antibiotics):

| Medication | When taken | Purpose |
| --- | --- | --- |
| | | |
| | | |
| | | |

**D. Additional Information**

Is there anything else I should know that might be helpful in understanding your child?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________