

Child Questionnaire

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Name

Pediatrician

Date of Birth

Age

Today's Date

Presenting Problem

What prompted you to seek counseling for your child at this time? Please provide some detail in your answer.

When did this first become a problem?

Is your child experiencing:

Depression	Sleep/appetite problems	Sexually acting out
Suicidal Thoughts	Violet behavior	Attention problems
Bingeing or Purging	Hyperactivity	School problems
Cutting Self	Nightmares	Poor/dropping grades
Anxiety or Panic Attacks	Flashbacks	Excessive mood swings
Bowel or bladder problem	Drinking/drug use	Irritability
Weight loss/gain	Bizarre behavior	Social Problems
Breaking the law	Openly defiant	Excessive fear

Has your child ever been seen in counseling before? If so, when and how long.

Please ask therapist to sign a release of information if you think prior therapist's records would be useful in treating your child.

Has your child ever been hospitalized for emotional difficulties before? When and for how long:

Health

Is your child on any medications? If so, please list:

Please list any allergies your child might have:

Are there any long-term / chronic medical problems? Please list:

Were there any problems during the pregnancy or labor? If so, please describe:

Did your child achieve all of the developmental milestones on time? (Weaning, talking, walking, toilet training, etc)

Has your child ever experienced a server head injury, especially one involving a concussion?

School

Name of School your child attends:

What grade is your child currently in?

What is you child's Grade Point Average?
(GPA)

Is your child in, or ever been in, RSP / Special
Education?

Is your child experiencing any behavioral problems in school? If so, please describe:

How would you describe your child's social adjustment?

Family

Please list the names and ages of your child's brothers and sisters, indicate which are Step, Half, or Full siblings.

Name(s)	Age(s)	Full/Half/Step
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Please list the names and relationships of important people to your child outside of the immediate family members:

Please describe a brief **History of the Family** if your child comes from a blended family, foster home, etc.:

Can you recall if either parent, grandparent, or siblings suffered from any of the following? If so please indicate:

Depression

- Father
- Mother
- Siblings
- Maternal Grandparents
- Paternal Grandparents

Anxiety

- Father
- Mother
- Siblings
- Maternal Grandparents
- Paternal Grandparents

Bi-Polar Disorder

- Father
- Mother
- Siblings
- Maternal Grandparents
- Paternal Grandparents

Substance/Alcohol Abuse

- Father
- Mother
- Siblings
- Maternal Grandparents
- Paternal Grandparents

Domestic Violence

- Father
- Mother
- Siblings
- Maternal Grandparents
- Paternal Grandparents

Miscellaneous

How important are religious beliefs within the family?

	Very	Significant	Average	Barely	Not At All
Importance					

If a parent or spouse has died, please indicate who and when (month / year) this happened.

Can you recall any traumatic event that your child has experienced in the past? (e.g. assault, rape molestation, kidnapping, natural disaster, server physical accident, etc.)

Has your child ever witnessed any type of domestic violence? (y/n)

Has alcohol and/or drugs ever been a problem for your child? (y/n)

Do you suspect any current drug or alcohol use? (y/n)

Does your child smoke cigarettes? (y/n)

Does your child consume a fairly healthy diet on a regular basis? (y/n)

Has your child ever been involved with the legal system? If yes, explain:

Please add anything else not already listed that would assist in treating your child: