Childs Name:		
Primary Care Physician:		
Address/City/State/Zip:		Clinic Telephone:
1. May we contact your Physician?: (Please Circle) YES	NO
2. When was the last time you saw yo	our physician?: (Date)	
3. What medical problems did you see	e your physician for?:	
4. What medical problems, if any, are	you currently having?:	
5. Are those problems being treated?:	(Please Circle) YES	NO By Whom?:
6. What medications are you currently	y using? Please include over	-the counter medications as well as herbal supplements:
7. List any medical problems that you	r child has been treated for	in the past?:
8. Is there a family history of medical	problems?: (Please Circle)	YES NO If yes, please list:
9. Is there any history of mental illnes	ss in your family?: (Please Ci	ircle) YES NO If yes, please describe:
		Circle) YES NO If so, please list with whom, dates and outcome of treatment.:
11. Please list any hospitalizations, se	rious illnesses, or operation	s including dates and where treated:
	s, please describe:	arning disability or other perceptual deficit/impairment?
		O Type Used:amount:
Outcome of treatment:		s (Please Circle): YES NO When, Where, and
16. Is there anything else in your child	d's medical history that wou	Id be helpful for us to know?:

NEW CLIENT INFORMATION PLEASE PRINT

Biological Mother's Address	Biological Father's Address
Name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:

Person(s) living with child (brothers, sisters, relatives, friends)

	, , ,	,	,			
Name:	Age:	□ Sister	□ Brother	□ Step-Sister	□ Step-Brother	□ Other
Name:	Age:	□ Sister	□ Brother	□ Step-Sister	□ Step-Brother	□ Other
Name:	Age:	□ Sister	□ Brother	□ Step-Sister	□ Step-Brother	□ Other
Name:	Age:	□ Sister	□ Brother	□ Step-Sister	□ Step-Brother	□ Other
Name:	Age:	□ Sister	□ Brother	□ Step-Sister	□ Step-Brother	□ Other
Name:	Age:	□ Sister	□ Brother	□ Step-Sister	□ Step-Brother	□ Other

Child's Daycare / Preschool or School

Name of School:	Director or Principal:
Street:	Primary Teacher:
City, State, Zip:	Other Significant Teacher, Counselor, Coach, etc.:
School Phone:	Other Significant Teacher, Counselor, Coach, etc.:

Child's Academic Status

	Child's General Academic Progress:			
Has the child been evaluated for any special	If yes, does the child have an Individual Education Plan			
needs by the school? \Box Yes \Box No	(IEP) in force? \Box Yes \Box No			

Child's Dhysisian

Child's Physician	Child's Current/Previous Therapist (if any)			
Physician's Name:	Therapists Name:			
Physician's Group or Clinic:	Therapist's Group or Clinic:			
Street:	Street:			
City, State, Zip	City, State, Zip			
Office Phone:	Office Phone:			
Fax Phone:	Fax Phone:			
Did the Physician refer the child? \Box Yes \Box No	Did the therapist refer the child? \Box Yes \Box No			
If no, may we contact the physician? \Box Yes \Box No				

CHILD HISTORY CHECKLIST

What concerns you most about this child?	
Has the child previously been evaluated and / or treated for this problem? \Box Yes \Box No	
What are you hoping we can do to help your child with this problem?	

Please answer the following questions by filling in the check to indicate Yes, No, or Not sure:

Child Medical / Developmental History		-	
Has the child had any of the following problems?	Yes	No	Not Sure
1. Difficult pregnancy / labor, delivery			
2. Problems with health, feeding and / or sleeping during first year of life			
3. Slow in learning to sit up, crawl, walk, feed self and / or dress self			
4. Speech and / or hearing problems			
5. Many ear infections requiring medication			
6. Frequent headaches, stomach aches / nausea, or other pains			
7. Major illness or hospitalizations (not including normal birth)			
8. Prescription medications taken within the past 2 months			
9. Other Problem(s)			

Child Behavioral History

Has your child shown any of the following behaviors within the past 6 months?	Yes	No	Not Sure
10. Performing below expectations at school in one or more academic areas			
11. Age-inappropriate fears, anxieties (including separation anxiety and school			
anxiety)			
12. Social withdrawal, excessive shyness, or avoidance behaviors			
13. Sleep disturbances (night terrors, nightmare, multiple night wakening, seeking			
others beds)			
14. Immature social skills, self-help skills, and / or communication skills			
15. Poor gross-motor skills (e.g. running) and / or poor fine motor skills (e.g.			
drawing, handwriting, using scissors)			
16. Antisocial behavior (fighting, theft, fire-setting, cruelty to animals, deceitfulness,			
drug / alcohol use, etc.			
17. Learning problems involving reading, writing, or math			
18. Abnormal responses to pain, sound, touch, clothing textures, light, and / or odors			
19. Tics, nervous habits, or unusual mannerisms			
20. Very strange or bizarre behaviors, interests, or ideas non-useful rituals or rigid			
rule-following			
21. Watching more than 2 hours of TV / Videos per day			
22. Talking about or threatening to hurt self			
23. Other behaviors or concerns:			

Family Medical / Behavioral History

Have any of the child's biological parents, siblings, or relatives had any of the	Yes	No	Not Sure
following problems?			
24. Migraine headaches, seizures, or other neurological conditions			
25. Thyroid condition			
26. Learning Problems			
27. Attention problems (with or without hyperactivity)			
28. Psychological problems			
29. Trouble with the law			
30. Drug and / or alcohol problems			
31. Verbal, physical and / or sexual abuse (as an abuser or as a victim)			
32. Other behaviors of concern:			

Family Social History

Is the family now experiencing any of the following difficulties or adjustments?	Yes	No	Not Sure
33. Parental marriage problems, separation, or divorce			
34. Child-custody dispute			
35. No members of extended family (grandparents, aunts, uncles, cousins)living in			
area			
36. No close friends of the family living in the area			
37. Child has no good playmates in the neighborhood			
38. Stressful living situation (e.g. too many daily "hassles", financial worries, legal			
problems)			
39. Discipline problems with other children in the family			
40. Unsafe neighborhood or community			
41. Sudden, serious illness or injury: long term illness; violence to, or death of			
family member			
42. Other important event(s):			

RELATIONSHIPS

Please place an (x) on any items that apply to your child.

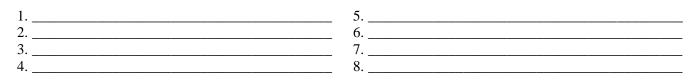
Too four friends	Hee even al friende
Too few friends	Has enough friends
Regularly talks/plays with friends	Often gets into fights with friends
Is overly shy	Withdrawing from friends
Makes friends easily	Finds it hard to keep friends
Others seem to be picking on my child	Bullying or mean to friends

_____ Plays mostly with younger children

_____ Hangs out with a "bad" crowd

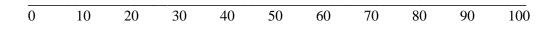
SOURCES OF STRESS

Please list the things/events/problems that are creating stress for your child at the present time.



CURRENT FUNCTIONING

Place and (x) on the following scale to indicate how well your child is coping with things at the present time. 100% means your child is coping the best he or she ever has.



YOUR CHILD'S GOALS IN COUNSELING

Please list the goals that you hope your child will achieve in counseling. (Be as specific as you can.)

1.	
2.	
3.	
4	
4.	

HOW MANY SESSIONS DO YOU THINK YOUR CHILD WILL NEED?

Please place an (x) in the answer which best describes your expectations.

1-3 session 4-6 sessions 7-9 sessions 10-12 sessions 12-14 sessions

_____ Other (please specify how many _____sessions.

Child's Name: _____

Date: _____

Below is a series of phrases that describe children's behaviors. Please circle the number (1-7) tat describes **HOW OFTEN** your child is showing the behavior indicated. Also, please circle **"YES"** if the child's behavior indicated is a problem for you.

	Never	Sel	dom	Sometime	0	ften	Always	A Problem for you?
1. Dawdles in getting dressed	1	2	3	4	5	6	7	Yes
2. Dawdles or lingers at mealtime	1	2	3	4	5	6	7	Yes
3. Has poor table manners		2	3	4	5	6	7	Yes
4. Refuses to eat food presented		2	3	4	5	6	7	Yes
5. Refuses to do chores when asked	1	2	3	4	5	6	7	Yes
6. Slow in getting ready for bed	1	2	3	4	5	6	7	Yes
7. Refuse to go to bed on time	1	2	3	4	5	6	7	Yes
8. Does not obey house rules on his/her own	1	2	3	4	5	6	7	Yes
9. Refuses to obey until threatened with punishment	1	2	3	4	5	6	7	Yes
10. Acts defiant when told to do something	1	2	3	4	5	6	7	Yes
11. Argues with parents about rules	1	2	3	4	5	6	7	Yes
12. Gets angry when does not get his/her own way	1	2	3	4	5	6	7	Yes
13. Has temper tantrums	1	2	3	4	5	6	7	Yes
14. Sasses adults	1	2	3	4	5	6	7	Yes
15. Whines	1	2	3	4	5	6	7	Yes
16. Cries easily	1	2	3	4	5	6	7	Yes
17. Yells or screams	1	2	3	4	5	6	7	Yes
18. Hits parents	1	2	3	4	5	6	7	Yes
19. Destroys toys or other objects	1	2	3	4	5	6	7	Yes
20. Is careless with toys and other objects	1	2	3	4	5	6	7	Yes
21. Steals	1	2	3	4	5	6	7	Yes
22. Lies	1	2	3	4	5	6	7	Yes
23. Teases and provokes other children	1	2	3	4	5	6	7	Yes
24. Verbally fights with friends	1	2	3	4	5	6	7	Yes
25. Verbally fights with brothers and/or sisters	1	2	3	4	5	6	7	Yes
26. Physically fights with friends his/her own age	1	2	3	4	5	6	7	Yes
27. Physically fights with brothers and/or sisters	1	2	3	4	5	6	7	Yes
28. Constantly seeks attention	1	2	3	4	5	6	7	Yes
29. Interrupts	1	2	3	4	5	6	7	Yes
30. Is easily distracted	1	2	3	4	5	6	7	Yes
31. Has short attention span	1	2	3	4	5	6	7	Yes
32. Fails to finish tasks or projects	1	2	3	4	5	6	7	Yes
33. Has difficulty entertaining self when alone	1	2	3	4	5	6	7	Yes
34. Has difficulty concentrating on one thing	1	2	3	4	5	6	7	Yes
35. Is overactive or restless	1	2	3	4	5	6	7	Yes
36. Wets the bed	1	2	3	4	5	6	7	Yes

Child Medical Questionnaire Rev. 7/11