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Questionnaire

Client's (Child's) Preferred Name | Birthdate

Child's Full Legal Name

Sex Assigned at Birth | Gender | Pronouns

Child's Race and Ethnicity | Birthplace City and State

Primary Language Spoken at Home | Other Languages Spoken at Home

Cultural, Religious or Secular Beliefs or Affiliations

Person Completing This Questionnaire

Referred By

Pediatrician or Primary Care Physician | Group

Address, Website or Phone Number | Date of Last Physical Exam

Is your child ever been married? ☐ Yes ☐ No

List dates of any mental health treatment (or school counseling) your child has ever received.

List any evaluations your child had (at school, private practices, clinics, agencies, etc.).

Please send copies of past evaluations, relevant school information, report cards, standardized test scores, etc. *before the appointment*.

Today's Date

Full Legal Name of Parent 1 | Birthdate

Preferred Name | Gender | Pronouns

Address | City, State ZIP

email | Phone | Other Phone

Full Legal Name of Parent 1 | Birthdate

Preferred Name | Gender | Pronouns

Address | City, State ZIP

email | Phone | Other Phone

Full Name of Emergency Contact | Relationship to Your Child

Address | City, State ZIP

email | Phone | Other Phone

Full Name of Emergency Contact | Relationship to Your Child

Address | City, State ZIP

email | Phone | Other Phone

Full Name of Telehealth Backup Contact (in case of tech issues) | Relationship to Your Child

email | Phone | Other Phone

Your Child's Address | City, State ZIP

Your Child's email | Phone | Other Phone

Length of Pregnancy _____ weeks

Length of Delivery _____ hours (from first labor pains to birth)

Mother's Age at Birth (of your child) _____ years

Your child's birth weight _____ pounds _____ ounces

Did your child's mother receive prenatal medical care? ☐ Yes ☐ No ☐ I don't know

During pregnancy, did your child's mother have:

☐ alcohol ☐ vaping or e-cigarettes

☐ marijuana ☐ tobacco (or other forms of nicotine)

☐ recreational or illicit drugs

List all prescription and over-the-counter medications used during pregnancy.

Did any of the following occur during pregnancy or delivery?

☐ unusual bleeding

☐ diabetes or excessive weight gain (more than 30 pounds)

☐ preeclampsia or toxemia (high blood pressure)

☐ Rh factor incompatibility

☐ infection or serious illness or injury

☐ frequent nausea or vomiting

☐ medication given to ease labor pains**—if so, name of medication**

☐ prolonged labor (longer than 4 hours)

☐ water broke more than 24 hours before delivery

☐ labor or delivery was induced

☐ forceps or suction was used during delivery

☐ breech delivery (feet first)

☐ planned or emergency Caesarian or C-section

☐ other problems**—please describe**

Did any of the following affect your child during delivery or within the first few days after birth?

☐ injured during delivery

☐ cardiopulmonary distress during delivery

☐ delivered with cord around neck

☐ had a low Apgar score

☐ had trouble breathing following delivery

☐ needed oxygen

☐ was cyanotic (turned blue)

☐ was jaundiced (turned yellow)

☐ had an infection

☐ had seizures

☐ was given medications**—if so, name of medications**

☐ born with a congenital defect**—please describe**

☐ was in the NICU (neonatal intensive care unit)**—please describe**

☐ was in the hospital more than 7 days**—please describe**

When did your child start:			**Describe any concerns about developmental milestones**
understanding “no”	_____	months	
saying single words (like “mama” or “dada”)	_____	months	
speaking, putting 2 or more words together	_____	months	
sitting without help	_____	months	
crawling	_____	months	
standing up, holding on to something	_____	months	
walking, without holding on to anything	_____	months	
using a toilet consistently, during the day	_____	years ☐ Not Yet	
staying dry overnight	_____	years ☐ Not Yet	
puberty	_____	years ☐ Not Yet ☐ I’m not sure	
having a period	_____	years ☐ Not Yet ☐ I’m not sure ☐ N/A	

Has your child ever had:

- ☐ asthma
- ☐ allergies
- ☐ diabetes, arthritis or other chronic illnesses
- ☐ epilepsy or seizure disorder
- ☐ febrile seizures
- ☐ chickenpox or other common childhood illnesses
- ☐ heart or blood pressure problems
- ☐ high fevers (over 103°F)
- ☐ broken bones
- ☐ severe cuts requiring stitches
- ☐ head injury, loss of consciousness, dizziness or fainting spells
- ☐ lead exposure or poisoning
- ☐ surgery (or an operation)
- ☐ lengthy hospitalization
- ☐ speech or language problems
- ☐ frequent colds or chronic ear infections
- ☐ hearing difficulties
- ☐ eye or vision problems
- ☐ eyeglasses
- ☐ fine motor or handwriting problems
- ☐ gross motor difficulties (clumsiness)
- ☐ appetite problems (overeating or undereating)
- ☐ sleep problems (falling asleep, staying asleep)
- ☐ soiling problems
- ☐ wetting problems
- ☐ other health difficulties or serious illnesses—**please describe**

How long does your child sleep per night? _____ hours

Does your child get enough sleep? ☐ Yes ☐ No ☐ I'm not sure

List all of your child's current medications, vitamins, herbs, supplements, or alternative medicines.

Name	Dose	Reason or Purpose

Has your child ever tried:

☐ alcohol
☐ marijuana
☐ others' prescriptions
☐ their own prescriptions not as prescribed
☐ over-the-counter medications not as directed
☐ vaping or e-cigarettes
☐ tobacco (or other forms of nicotine)

List any other substances your child has ever tried.

Has your child ever experienced any of the following?

☐ family moved to another city or another part of town
☐ changed schools
☐ being bullied or harassed at school or in the neighborhood
☐ family financial struggles
☐ homelessness
☐ lived in a home with domestic violence
☐ witnessed violence or abuse
☐ abuse (or neglect)
☐ talking about suicide or wanting to be dead
☐ suicide attempt
☐ talking about seriously harming someone
☐ attempt to seriously harm someone
☐ running away from home
☐ approached for sex
☐ arrest(s) or involvement in juvenile justice
☐ illegal activities that were not caught
☐ any unusual or stressful events—**please describe**

Does your child:

If not, why?

☐ have the ability to be trusted to care for a pet
☐ handle their personal finances (e.g., allowance)
☐ take responsibility for their personal hygiene

Does your child: **How many friends does your child have?** _____

- ☐ prefer being with younger children
- ☐ prefer being with older children
- ☐ prefer being with adults
- ☐ have a best friend
- ☐ have a romantic companion (e.g., girlfriend or boyfriend)

List your child's sports, recreational, free-time, and work/employment activities and interests.

What do you enjoy doing with your child?

What are your child's strengths?

How many academic or behavior problems did your child have at school each school year?

	none	some	a lot	Name of School (without using abbreviations)
Daycare	☐	☐	☐	
4-year-old Preschool	☐	☐	☐	
Kindergarten	☐	☐	☐	
1st Grade	☐	☐	☐	
2nd Grade	☐	☐	☐	
3rd Grade	☐	☐	☐	
4th Grade	☐	☐	☐	
5th Grade	☐	☐	☐	
6th Grade	☐	☐	☐	
7th Grade	☐	☐	☐	
8th Grade	☐	☐	☐	
9th Grade	☐	☐	☐	
10th Grade	☐	☐	☐	
11th Grade	☐	☐	☐	
12th Grade	☐	☐	☐	

Describe any problems at school.

Does your child like school? ☐ Yes ☐ Mostly ☐ Sometimes ☐ No ☐ I'm not sure

Have you spoken to or met with your child's: ☐ teacher ☐ school counselor ☐ principal

Has your child ever had any of the following?

- ☐ Speech (or Language) Services
- ☐ Occupational Therapy
- ☐ Tutoring (or Remedial Services)
- ☐ Section 504 Plan
- ☐ Special Education (e.g., IEP)
- ☐ Early Childhood Special Education (e.g., Early Intervention, IFSP)
- ☐ Summer School (e.g., Extended School Year)
- ☐ FBA (Functional Behavioral Assessment), BSP (Behavioral Support Plan) or Safety Plan
- ☐ Disciplinary Actions (e.g., in-school suspension, out-of-school suspension, expulsion)
- ☐ any other school-related support services

Describe any of the above that you marked.

Home(s): Provide your child's primary home address and list who else lives there (plus any pets).
If your child has another home, provide information about that home on the next page.

Home Address		City	State	ZIP

Name	Relationship to Your Child (mom, step-dad, half-sister)	**Children:** School & Current Grade **Adults:** Occupation & Highest Level of Education	Gender	Pronouns (he, she, they)	Age

Describe this family's cultural, religious or secular beliefs or affiliations.

List adoptions, separation or divorce dates, parenting time schedule, and any other major changes in the family.

List this family's favorite activities.

How frequently does your child see grandparents? _____

Who cares for the child(ren) when parents are at work or gone? _____

Home Address **(if applicable)**		City	State	ZIP
Name	(mom, step-dad, half-sister) Relationship to Your Child	**Children:** School & Current Grade **Adults:** Occupation & Highest Level of Education	Gender	(he, she, they) Pronouns	Age

Describe this family's cultural, religious or secular beliefs or affiliations.

List adoptions, separation or divorce dates, parenting time schedule, and any other major changes in the family.

List this family's favorite activities.

How frequently does your child see grandparents from this family? _____

Who cares for the child(ren) when parents are at work or gone? _____

(Aunt/Uncle) Parent's Sibling	Grandparent	Sibling	Parent	**Have your child's relatives ever had any of the following?**
				inherited medical conditions
				language or learning disability
				ADD or ADHD
				Autism, Asperger's, or a developmental problem
				depression or an emotional problem
				anxiety, nervousness, or a nervous breakdown
				bipolar, schizophrenia or psychosis
				diabetes
				eating disorder
				seizures or epilepsy
				problems with drugs or alcohol
				arrests, violence toward others, trouble with the police, or criminal involvement
				accused of child abuse or neglect
				suicide or suicide attempts
				mental hospitalization
				treatment for other mental conditions

On the lines above, describe the relationship to the child (e.g., mom, dad's dad, etc.).
In the space below, provide any relevant details.

List any close family, friends, or pets who have died or had a major illness within your child's lifetime.

Name	Relationship to Your Child	Dates or Years of Illness	Date or Year of Death

Have there been recent changes in your child's:

- ☐ sleep
- ☐ diet
- ☐ appetite
- ☐ screen-time
- ☐ activities
- ☐ hobbies
- ☐ interests
- ☐ reading

What books, workshops, blogs, religious teachings, etc. influence your parenting style?

What are you concerned about with your child?

What have you tried (e.g., other therapists, medications, or any "non-traditional" treatments)?

What do you want to address in this consultation?

What else should I know?