Rachel Lacy, Psy.D., P.C.
3883 Rogers Bridge Road, St.e 302A
Duluth, GA 30097

CHILD QUESTIONNAIRE

Confidential

Information requested on this questionnaire will aid us in understanding your problems. We would appreciate you filling it out carefully and fully. Please feel free to add as much information as you want. You may use the backs of pages if necessary.

Name_____ **Date**_____

Age_____ **Sex**_____ **School**_____**Grade**_____

In the next section please describe yourself in regard to each of the following aspects of thinking, feeling, or behavior. Describe the situation before the accident or illness on the left and the recent or current on condition on the right. ***If the condition is one that you have had all of your life, then only complete the column on the left side of the page.***

Before the accident or illness	**Recently and currently**
Concentration	
_____	_____
_____	_____
Energy and activity level	
_____	_____
_____	_____
Depression	
_____	_____
_____	_____
Elation and other types of high mood	
_____	_____
_____	_____
Sleep	
_____	_____
_____	_____
Anger or Anger Control Problems	
_____	_____
_____	_____
Agitation or Irritability	
_____	_____
_____	_____

Before the accident or illness	Recently and currently
Running Away or Oppositional Behavior	
Appetite for food	
Sexual behavior and sexual interest	
Consumption of alcohol and other drugs	
Hearing	
Vision and other aspects of sight	
Ability to find way around - Spatial ability	
Headaches	
Pains other than in the head	
Fatigue	
Understanding what you hear	
Your ability to finding words when you know what you want to say	

Before the accident or illness **Recently and currently**

Your memory for things people say or things you need to do

_____ _____
_____ _____

Imagery and memory for faces

_____ _____
_____ _____

Reading

_____ _____
_____ _____

Calculating - balancing check book

_____ _____
_____ _____

School work

_____ _____
_____ _____

Playing or listening to music

_____ _____
_____ _____

Motor behavior - skillful activity

_____ _____
_____ _____

Unusual sensations or strange experiences

_____ _____
_____ _____

Ability to relax and experience pleasure

_____ _____
_____ _____

Social behavior - being with people

_____ _____
_____ _____

Please use the back page for additional information which you think would be helpful.
If another person assisted in completing this form, please enter appropriate information below.

Name _____ **Relationship to client**_____
Address_____**Phone**_____