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Client Questionnaire-child

*****IF COURT ORDERED OR HAVE CUSTODY AGREEMENT, BRING COPY OF COURT DOCUMENTATION****

Demographics:

Client Legal Name _____ D.O.B.: _____ Age: _____

Client Preferred Name:_____

Current address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Ok to leave voice/text message: ◯Yes ◯No

Cell/Other #: _____ Ok to leave voice/text message: ◯Yes ◯No

Email: _____

Gender: ◯ Male ◯ Female ◯Transgender ◯Other_____

Race/Ethnicity: ◯ African American ◯ Asian-American ◯ Caucasian ◯Asian

◯ Native American ◯ Hispanic ◯ Biracial/Multiracial

◯Other: _____

Marital Status: ◯ Single ◯Cohabitating ◯ Married ◯ Separated ◯Divorced ◯ Widowed

Sexual Orientation: ◯ Heterosexual/Straight ◯ Lesbian/Gay ◯Bisexual ◯ Other_____

Emergency Contact: _____ Relationship:_____ Ph#:_____

How were you referred to Kathleen Hurley? _____

Family of Origin:

My child is being raised by: ◯ Biological Parents ◯ Single Parent ◯Foster/Adoptive Family

◯ Grandparent(s) ◯Other: _____

Name of father:_____ Name of mother:_____

Custody arrangement for child (**MUST BRING DOCUMENTATION OF CUSTODY ARRANGEMENT**):

_____

_____

Is your family or child involved, or has ever been involved with Children's Division/Department of Child & Family Services (CD/DCFS)? ◯Yes ◯ No
If yes, explain: _____

_____

_____

Name of CURRENT Household Members, Relationship, and Age:

Name	Relationship	Age

Education/Academic History:

Education History to date: ◯ Elementary School ◯ Middle School ◯ High School ◯ GED

◯ High School Diploma ◯Trade/Technical School ◯ Some College ◯ Associate's Degree

◯Bachelor's Degree ◯ Master's Degree or Above ◯Other: _____

If currently attending school,
School Name:_____

Address:_____

Current Grade:_____ Teacher's Name:_____

Current GPA:_____ Average GPA:_____

Type of classroom setting:
◯Regular ◯Resource ◯Special School District ◯Home Schooled ◯ Other

History of behavioral problems in school (detention, suspended, expelled)? ◯Yes ◯No
If yes explain,_____

_____

_____

Academic Struggles/Learning Disabilities or repeated grades: ◯Yes ◯No
Explain:_____

_____

Childhood Relationships:
Was your child a victim of emotional, physical, or sexual abuse/violence? ◯Yes ◯No
Explain:_____

_____

_____

Did your child witness any emotional, physical, or sexual abuse? ◯Yes ◯No
Explain:_____

_____

_____

Additional childhood experiences that caused distress? ◯Yes ◯No

Explain:_____

Substance Use History: (if answering for minor answer to the best of your ability)
Do you believe that your child has experimented or is currently using alcohol, illegal drugs, or misusing RX drugs? ◯ Yes ◯ No
If yes:(Please list age when started, types of substances used, and current usage):

_____

_____

_____

_____

Has your child ever participated in substance abuse treatment? ◯Yes ◯No

If Yes, Where? _____When? _____

Is there a family history of substance usage? ◯Yes ◯No
Explain:_____

_____

_____

Have you spoken to your child about the dangers of drugs and alcohol? ◯ Yes ◯ No

Lifestyle:

What activities does your child enjoy in their free time? (exp: clubs, music, crafts, sports):_____

_____

_____

Has there been a change in your child's interests in activities they once enjoyed? ◯ Yes ◯ No

Explain:_____

_____

Who does your child depend on for emotional support? _____

Is your child involved in community or self-help groups? ◯ Yes ◯ No

If yes, list groups:_____

What is your child's religious background and/or spiritual beliefs? _____

Is your child active or still participate in these spiritual practices? ◯ Yes ◯ No

Explain: _____

_____

Please indicate what your child's strengths are:

_____

_____

Legal History:

Has your child ever been arrested/detained and/or charged with any crimes? ◯ Yes ◯ No

If yes explain:_____

_____

Current Court Involvement:

◯ None ◯ Probation ◯Pending Charges ◯Lawsuit ◯ Divorce/Child Custody

◯Other_____

Mental Health History:

Has your child had previous counseling, psychotherapy, or psychiatric care? ◯Yes ◯No

If yes, describe past treatment history, including dates, providers, types of services received, and diagnoses:_____

_____

_____

_____

Has your child ever had thoughts of suicide? ◯Yes ◯No Attempted suicide? ◯Yes ◯No

If yes explain, _____

_____

Does your child currently or has a history of self harm behaviors (cutting, burning, etc)? ◯Yes ◯No

Explain:_____

_____

What mental health concerns do you have for your child?

_____

_____

_____

Family history of mental illness? ◯Yes ◯No
Explain:_____

_____

_____

Medical History:

Height: _____ Weight: _____ Date of Last Physical Exam: ____/____/_____

Primary Care Physician: _____ Physician Phone Number: _____

Psychiatrist:_____ Psychiatrist Phone Number:_____

Indicate any medical conditions currently affecting your child:

_____

_____

Please list all prescription medications, over the counter medications, and supplements you are currently taking.

Name	Dosage	Frequency	Start Date	Prescribing Physician	Purpose of Rx

Do you take your medication as prescribed? ◯ Yes ◯No

Reason for seeking counseling services:

What triggered seeking counseling services now?

_____

_____

_____

_____

When did the symptoms start? When are they present? Not present?

_____

_____

_____

_____

What do you hope to accomplish through counseling? (List three specific goals for yourself):

1._____

2._____

3._____