CHILD AND ADOLESCENT LIFE HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to gather a thorough understanding of your (your child's) life experience and background. Please respond as completely as you can and are willing to as this will benefit the development of your plan for treatment.

General and Demographic Information

Name of Client: ______________________________________ Birthdate: ______________

Name of Person Completing form/Relationship to Client: ____________________________

Address: ________________________ City: _______________ State: _____ Zip: _____

Parent: Preferred Phone #: _________________ Is this your (circle): Cell Home Work

Can we: Call? __Y __N Leave a voicemail? __Y __N Text? __Y __N

Can we e-mail? __Y __N E-mail address: ____

Adolescent: Preferred Phone #: __________________ Is this your (circle): Cell Home

Can we: Call? __Y __N Leave a voicemail? __Y __N Text? __Y __N

Can we e-mail? __Y __N E-mail address: ____

Preferred method of contact (circle): Call Text E-mail

How did you find Silver Linings Counseling? ______________________________________

How long have you lived at your current address? _________________________________

Of what race do you consider yourself? ____

What is your religious preference, if any? _______________________________________

Emergency Contact/Relationship to Client: _______________________________________

Primary phone: _________________________ Alternate phone: ____________________

Primary Insurance Provider: ____

Name of Subscriber/Relationship to Client: _______________________________________

Subscriber's Employer: ____

Subscriber's Birthdate: _______________ Subscriber's Phone #: ___________________

Secondary Insurance Provider: ____

Name of Subscriber/Relationship to Client: _______________________________________

Subscriber's Employer: ____

Subscriber's Birthdate: _______________ Subscriber's Phone #: ___________________

What brings you in today?

____

When did your problem begin? ____
What are your goals for treatment? ____
____

Please rate your progress on your goals on the scale below:
(Not achieved at all) 0 1 2 3 4 5 6 7 8 9 10 (Totally achieved)

Medical History

What is your height? _____ feet _____ inches What is your weight? _______ pounds
How much exercise do you get a week? _______________ hours Type: _____________

How many times have you been hospitalized for a medical reason in your lifetime? ______

Date	Reason for Hospitalization	Length of Stay
_________	___________________________________	___________________
_________	___________________________________	___________________
_________	___________________________________	___________________

What medical problems are you currently experiencing, if any? _____________________
____
What medical problems have you had in the past, if any? ___________________________
____
What medications are you currently prescribed, if any? ____________________________
____
Do you find these medications to be helpful in treating your symptoms? ____Yes ____ No
If not, please explain: ____

Are your immunizations up-to-date? ____ Yes ____ No
If no, please explain ____

Please indicate any current or past problems or delays in development:

Age		Age		Age	
_____	serious illness	_____	allergies	_____	hyperactivity
_____	serious surgery	_____	anemia	_____	diabetes
_____	dental problems	_____	fainting	_____	earaches
_____	weight problems	_____	headaches	_____	head injury
_____	heart problems	_____	high fevers	_____	seizures
_____	vision problems	_____	dizziness	_____	sinus problems
_____	stomach problems	_____	asthma	_____	skin problems
_____	hearing problems	_____	speech problems		

Other: ____

Developmental History

Please circle if you know if your mother used any of the following during pregnancy:

Alcohol Tobacco Marijuana Illicit drugs Unsure

Did your mother experience any complications during:
Pregnancy __ Yes __ No Labor/delivery __Yes __ No Postpartum __Yes __ No

Were you born prematurely? __ Yes __ No

How are your relationships with siblings and other children? ________________________
____

What special interests, abilities, and skills do you have? ___________________________
____

What fears or habits do you have? ____
____

Educational/Social/Legal/Employment History

In what grade are you currently? ____________ Do you like school? __Yes __No
How many schools have you attended in your lifetime? ___________
In what types of classes do you currently participate?
__Regular __Emotionally Impaired __Cognitively Impaired __Gifted/Talented
Other: ______________________________ Do you have an IEP or 504b? __Yes __No
Have you skipped a grade? __Yes __No Have you repeated a grade? __Yes __No

Have you completed any formal psychological testing/assessment in school? __Yes __ No
If yes, please explain: ____
Have you been diagnosed with any specific learning disabilities? __Yes __ No
If yes, please explain: ____
Please describe your attendance at school: _______________________________________
Please describe your behavior at school: ____
Have you ever been suspended or expelled? __ Yes __ No
If yes please explain: ____
Please describe your academic performance at school: ______________________________
In what afterschool activities do you participate? _________________________________
With whom do you spend most of your free time? _________________________________
Are you happy with the number of friends you have? __ Yes __ No

Are you currently or have you ever been employed? __ Yes __ No

Was this episode of treatment prompted by the criminal justice system? __ Yes __ No
Have you ever been in trouble with the police? __ Yes __ No
Have you ever appeared in juvenile court? __ Yes __ No
Have you ever been on probation? __ Yes __ No
Are presently awaiting charges, trial, or sentencing? __ Yes __ No

Family History

My parents are: __Married (how long? ______) __ Divorced __ Separated
__Never Married __ Living together only
__ Deceased: Please explain: ____________________________________
I was adopted: __ Yes __ No Please explain: ______________________________________
____

Family Members

Name	Relationship	Age	Quality of Relationship	Living with you?
________________	____________	_____	______________________	_____________
________________	____________	_____	______________________	_____________
________________	____________	_____	______________________	_____________
________________	____________	_____	______________________	_____________
________________	____________	_____	______________________	_____________

Have you ever lived away from your family? __ Yes __ No
If yes, please explain: ____
Have you had any serious conflicts with family members in the past 30 days? __ Yes __ No
If yes, please explain: ____
Have you had any serious conflicts with family members ever? __ Yes __ No
If yes, please explain: ____

Substance Use History

Please indicate the frequency with which use any of the following substances:

Substance	Age of First Use	Current Use (# of days/last month)	Past Use (# of days/average month)
Caffeine			
Tobacco			
Alcohol			
Marijuana			
Sedatives			
Cocaine			
Heroin			
Barbiturates			
Inhalants			
Hallucinogens			
Other:			

How many times have you been treated for alcohol or drug-related problems? _______

Date	Length/Type of Treatment	Length of Abstinence
__________	______________________________________	____________________
__________	______________________________________	____________________
__________	______________________________________	____________________

Mental Health History

Have you completed any formal psychological testing outside of school? __ Yes __ No
If yes, what were the diagnostic results? ____
Is there any family history of mental health or substance abuse problems? __ Yes __ No
If yes, please explain: ____
____
Are you currently being prescribed medication for a mental health issue? __ Yes __ No
If yes, please list name of medication and dosage as well as prescribing doctor's name:
____
____

Do you feel the medication is helping your symptoms? __ Yes __ No
If no, please explain: ____

How many times have you been treated for mental health? ________________________

Date	Reason for Treatment	Length/Type of Treatment
_________	____________________________	_________________________
_________	____________________________	_________________________
_________	____________________________	_________________________

Would you like us to obtain your records from your previous therapists? ___ Yes ___ No

Please indicate below if you have ever experienced a significant period of:
Serious depression: ___ Yes ___ No
Please explain: ____
Serious anxiety: ___ Yes ___ No
Please explain: ____
Hallucinations/delusions: ___ Yes ___ No
Please explain: ____
Trouble understanding, concentrating, or remembering: ___ Yes ___ No
Please explain: ____
Trouble controlling aggression or violent behavior: ___ Yes ___ No
Please explain: ____
Serious thoughts of suicide: ___ Yes ___ No
Please explain: ____
Have you ever attempted suicide: ___ Yes ___ No Number of attempts: ____
Please explain: ____
____

Has anyone ever abused you emotionally, physically, or sexually? ___ Yes ___ No
Please explain: ____
____

Have you ever experienced or witnessed a traumatic event? ___ Yes ___ No
Please explain: ____
____

Circle any of the following words that apply to you:

worthless	ashamed	a “nobody”	full of hate	“can’t do anything right”
inadequate	stupid	incompetent	morally wrong	panicky/worried
guilty	evil	hostile	aggressive	horrible thoughts
anxious	ugly	unattractive	repulsive	depressed
lonely	unloved	unconfident	restless	misunderstood

Please list as many of your strengths as possible: ______________________________
____

Signature: _________________________________ Date: ______________________