CHILD QUESTIONNAIRE

Please NOTE: all the information you share is for your counselor only and not shared with anyone else.

NAME: _____ Age _____ Date _____

Who wanted you to come here today? *Please check all that apply*

___ Myself ___ Parents ___ Teacher ___ Friend ___ Other: _____

Is it OK to be here today?

___ It's fine with me

___ I don't care either way

___ I'm against this

Have your parents/caretakers told you anything about coming here? Or why they want you to come here? *If yes, what?* _____

_____

SCHOOL

Do you go to school? ___ Yes ___ No ___ Homeschool Grade _____

Name of School: _____

Do you play Sports there? _____

Do you play Music there? _____

Do you draw or paint there? _____

What do you like the most about school? _____

_____

What do you NOT like about school? _____

_____

ACTIVITIES/INTERESTS

What is your favorite thing to play? _____

_____

What do you wish you could do but you are not allowed or not old enough? _____

_____

Do you play with a lot of friends your age? ___ Often ___Sometimes ___ Not very often

Do you spend a lot of time playing with your friends? ___ Yes ___ No

Do you have a best friend? ___ Yes ___ No**; How long have you known him/her?**_____

What do you like best about him/her? _____

When you get hurt or feel bad, who do you go to for help? _____

Do kids at school or in your neighborhood tease you or call you names? ___ No ___ Yes**; what do they say or call you?** _____

How do you think about grownups? *Please check all that apply*

___ Helpful
___ Friendly
___ Make a lot of rules
___ Smart or wise most of the time
___ Can be trusted and counted on
___ Usually mean
___ Don't understand me
___ Caring
___ Jerks
___ Stupid or dumb most of the time
___ Can't be trusted, let me down
___ Usually nice

HEALTH

Do you have to go to the doctor a lot? ___ No ___ Yes

Check all that apply to you:

___ I have headaches once a week or more
___ I have gained 10 pounds or more within the past two months
___ I have lost 10 pounds or more within the last 2 months
___ I hurt a lot
___ I have a hard time falling asleep
___ I wake up a lot during the night
___ I wake up very early and can't go back to sleep
___ I have bad dreams ___ a lot ___ sometimes ___ the same ones over again
___ I feel tired a lot
___ I have a hard time listening
___ I am forgetful
___ I have bad thoughts
___ I think about dying
___ I think about hurting others

Check all the feelings that you often have:

___ **Happy** ___ **Sad** ___ **Angry** ___ **Afraid** ___ **Worried** ___ **"Touchy"**
___ **Bored** ___ **Confused** ___ **Shy** ___ **Hyped Up** ___ **Guilty** ___ **Lonely**
___ **Disappointed** ___ **Feel I am fine just the way I am** ___ **Excited**
___ **Feel bad about myself** ___ **Feel not good enough**

DRUGS AND ALCOHOL **Has anyone ever given you:** *Check all that apply*

___ Alcohol ___ Marijuana ___ Acid/LSD?
___ Cigarettes ___ Cocaine/Crack ___ Prescription Drugs
___ Other: _____

Have you tried alcohol, cigarettes and/or other drugs on your own? *If yes, what kind?* _____

_____

FAMILY

What do you like BEST about your family? _____

_____

What do you like the LEAST about your family? _____

_____

Who do you get along with the BEST in your family? Why? _____

_____

If you had three wishes, what would you change about your family?

1. _____
2. _____
3. _____

PAST

Think back to when you were real little. What do you first remember? _____

_____

_____

Who did you grow up with? _____

Were there any major changes in your life in the past 5 years? ___ No ___ Yes; *Check all that apply:*

___ We moved

___ My parents got divorced

___ A family member or friend died; Who? _____

___ I lost a friend

Have you ever experienced emotional/physical and/or sexual abuse? *If yes, please explain*

_____

_____

Do you or have you harmed yourself? *If yes please explain,* _____

_____

Are you currently being abused in any way? *If yes, please explain* _____

_____

_____

Is there anything else that you would like to tell me? _____

_____

_____

I AM VERY HAPPY TO MEET YOU!!