ADOLESCENT BACKGROUND AND HISTORY QUESTIONNAIRE
(To be completed by parent/guardian)

Child's Name_____ Date of Birth_____

Form Completed By_____ Today's Date_____

Living situation (check all that apply):

____ Child lives with both biological parents
____ Child lives with biological mother
____ Child lives with biological father
____ Child lives with adoptive mother and father (Age at adoption_____)
____ Other arrangement (please explain)_____

Who lives in the home with your adolescent?

Name Relationship to child Age

_____
_____
_____
_____
_____
_____
_____
_____

Are there any siblings not living in the home?

Name Relationship to child Age

_____
_____
_____
_____

If the parents are divorced or unmarried, what is the current legal custody arrangement?

_____

If parents are divorced or unmarried, what is the frequency of contact between your child/adolescent and the non-custodial parent?

_____

Pregnancy and Delivery

Did the child's birth mother smoke during pregnancy?	YES	NO
Did the child's birth mother drink alcohol during pregnancy?	YES	NO
Did the child's birth mother use drugs during pregnancy?	YES	NO
Did the child's birth mother receive prenatal care during pregnancy?	YES	NO

Please describe any complications with the pregnancy or delivery:

Developmental Milestones

Please indicate the approximate age at which your child/adolescent achieved each of the following developmental milestones:

Developmental Task	Age
First words	_____
Crawled	_____
Walked without support	_____
Toilet trained	_____

Education

Where does your adolescent currently attend school?

_____

What grade is your adolescent in? _____

Has your adolescent ever skipped a grade? YES NO

Has your adolescent ever repeated a grade? YES NO

Does your adolescent receive any special academic services (e.g. special education, tutoring, gifted program)? YES NO

If yes to above question, please describe:

_____
_____

Please describe any academic or school-related concerns that you have with regard to your adolescent:

_____
_____
_____
_____

Parents' highest grade completed: Mother _____ Father _____

Medical History

Name and address of child's pediatrician or primary care physician:

_____
_____
_____

Are your child's immunizations up to date? YES NO

Has your child been diagnosed with any of the following medical conditions?

____ Asthma ____ Allergies ____ Cancer or blood disease
____ Cystic Fibrosis ____ Diabetes ____ Headaches/Migraines
____ Obesity ____ Kidney disease
____ Liver disease ____ Gastro-intestinal condition
____ Other (Please specify _____)

If yes to any of the above conditions, please describe the treatment regimen:

_____
_____
_____

Does your child have any food or drug allergies? YES NO DON'T KNOW
If yes, specify_____

Do you have any concerns with your child's dietary habits? YES NO
If yes, specify _____

Has your adolescent had a significant appetite change in the last month? YES NO
Comments:_____

Do you have any concerns with your child's sleeping patterns? YES NO
If yes, please specify _____

Has your adolescent had a significant change in sleep patterns in the last month?
YES NO
Comments:_____

Behavioral/Emotional Health History

Please indicate any past or present behavioral or emotional concerns:

	Past	Present
Inattention	____	____
Hyperactivity	____	____
Fears/Phobias	____	____
Sad/Depressed mood	____	____
Eating concerns – extreme pickiness	____	____
Eating concerns – strict dieting	____	____
Eating concerns – overeating	____	____
Eating concerns – binging and purging	____	____
Eating concerns – excessive exercise	____	____
Learning problems	____	____
Difficulty getting along with peers	____	____
Social skills problems	____	____
Victim of teasing or bullying	____	____

Bullying other children	____	____
Arguing with adults	____	____
Physically harming other people or animals	____	____
Threatening physical harm to anyone	____	____
Fire starting	____	____
Running away from home	____	____
Talking about or attempting suicide	____	____
Cutting or mutilating body	____	____
Obsessive thoughts and/or actions	____	____
Drug or alcohol use	____	____
Motor tics	____	____
Stuttering	____	____

Other concerns (please specify) _____

Has your child had previous <u>outpatient</u> psychological treatment? YES NO

Name of therapist Dates of treatment Reason for treatment

_____
_____
_____
_____

Has your child had previous <u>inpatient</u> psychological treatment? YES NO

Name of program/facility Dates of treatment Reason for treatment

_____
_____

Has your child ever had a psychological or psycho-educational evaluation?
YES NO
If yes, what were the results?

_____
_____
_____

Has your adolescent taken any medication <u>in the past</u> to address emotional, behavioral or academic problems? If so please specify:
Medication Dosage Reason

_____
_____
_____
_____

Is your adolescent currently taking any medication (prescription, over-the-counter, vitamins, herbs, or supplements) for emotional, behavioral, academic, or medical reasons?

Medication Dosage Reason

_____
_____
_____
_____
_____
_____

Sexuality

To the best of your knowledge your adolescent is/has

Sexually active	YES	NO	UNKNOWN
Using contraceptives	YES	NO	UNKNOWN
History of pregnancy	YES	NO	UNKNOWN
History of abortion	YES	NO	UNKNOWN
Fathered a child	YES	NO	UNKNOWN

Do you have any concerns regarding your adolescent's sexual development or sexual orientation? If so please comment: _____
_____
_____

Alcohol and Drugs

Please describe your adolescent's pattern of alcohol and/or drug usage and any concerns you may have:

_____
_____
_____

Significant Events

Please check any significant events your adolescent has experienced:

____ Change of school
____ Move to a new place
____ Loss of someone close to the adolescent
____ Serious illness or injury to a family member or friend
____ Death in the family
____ Frightening experience for the adolescent
____ Divorce or separation
____ Change in family structure (someone moved in/out of home, blending of families)
____ Victim of physical abuse
____ Victim of sexual abuse
____ Victim of rape/sexual assault
____ Witnessed domestic violence

____ Other significant trauma (please specify)_____

Family Health History

Have any family members (siblings, parents, aunts, uncles, cousins or grandparents) been diagnosed or treated for a mental health or substance abuse problem?
YES NO DON'T KNOW

Please explain if yes to above question:
_____
_____
_____
_____

Present Concerns

Name and address of referring person
_____
_____
_____

What are your biggest concern(s) regarding your child/adolescent?
_____
_____
_____
_____
_____

What do you hope to accomplish in therapy?
_____
_____
_____
_____
_____

What are your child's strengths?
_____
_____
_____
_____

Are there any cultural, racial, sexual orientation and/or religious issues that need to be considered when planning your adolescent's treatment?
_____
_____
_____
_____

Thank you for completing this questionnaire.