



**PSYCHOLOGICAL SERVICES  
CHILD QUESTIONNAIRE**

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Referred By: \_\_\_\_\_

Name of Person Completing Form: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Name of Child's Legal Guardian: \_\_\_\_\_

If not the legal guardian, has the legal guardian given you permission to represent him/her? **Y** **N** If yes, please provide documentation to office staff.

State all reason(s)/problem(s) for which you are seeking services for your child at Jacobs Ladder Psychological Services, PLLC right now:

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Date the child's problems (Illness/Condition) began: \_\_\_\_\_

Date the child first had trouble in school/home because of their illness/condition: \_\_\_\_\_

Date the child could no longer function in school/home because of their illness/condition: \_\_\_\_\_

**LIVING ARRANGEMENTS**

Place of Birth: \_\_\_\_\_ Place grew up/raised in: \_\_\_\_\_

Does child live with both birth parents? **Y** **N** If no, who is the adult that child lives with and their relationship to the child? \_\_\_\_\_

Reasons for absence of birth parents: \_\_\_\_\_

DOES CHILD STILL HAVE A RELATIONSHIP WITH BIRTH PARENTS? **N** **Y** HOW OFTEN DOES BIRTH

**CHILD QUESTIONNAIRE**

PARENT(S) CONTACT THE CHILD? \_\_\_\_\_

NAMES AND AGES OF BIOLOGICAL **BROTHERS AND SISTERS WHO LIVE THE WITH THE CHILD:**

NAMES, AGES, RELATIONSHIP OF OTHERS LIVING IN THE HOME: \_\_\_\_\_

**BIOLOGICAL SISTERS/BROTHERS OF CHILD OUTSIDE THE HOME:** \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

COMPLICATIONS DURING PREGNANCY/BIRTH: \_\_\_\_\_

WAS THE CHILD EXPOSED TO DRUGS BEFORE BIRTH:

- YES
- NO

**CHILD'S EARLY DEVELOPMENT:**  ON TIME  ONLY SOME AREAS DELAYED

DELAYED IN MOST AREAS

Check only those your child ***DID NOT DO*** at expected age:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> SITTING                    | <input type="checkbox"/> RIDING TRICYCLE       | <input type="checkbox"/> TOILET TRAINED (BLADDER)       |
| <input type="checkbox"/> WALKING                    | <input type="checkbox"/> RIDING BICYCLE        | <input type="checkbox"/> TOILET TRAINED (BOWEL)         |
| <input type="checkbox"/> SINGLE WORDS               | <input type="checkbox"/> DRESS SELF            | <input type="checkbox"/> SCRIBBLES                      |
| <input type="checkbox"/> TWO/THREE WORD SENTENCES   | <input type="checkbox"/> TIE SHOES             | <input type="checkbox"/> WRITE NAME                     |
| <input type="checkbox"/> TALK IN COMPLETE SENTENCES | <input type="checkbox"/> SEPARATE FROM PARENTS | <input type="checkbox"/> PLAY COOPERATIVELY WITH OTHERS |

**NEGLECT, PHYSICAL AND SEXUAL ABUSE HISTORY**

**NEGLECT:**  YES  NO IF YES, PLEASE EXPLAIN BELOW AND **GIVE DATES:**

**PHYSICAL ABUSE:**

OBSERVED:  YES  NO EXPERIENCED:  YES  NO

IF YES TO EITHER, PLEASE EXPLAIN BELOW AND **GIVE DATES:** \_\_\_\_\_

# CHILD QUESTIONNAIRE

## SEXUAL ABUSE:

OBSERVED:  YES  NO EXPERIENCED:  YES  NO

IF YES TO EITHER, PLEASE EXPLAIN BELOW **GIVE DATES:** \_\_\_\_\_

## MENTAL HEALTH HISTORY

MENTAL HEALTH TREATMENT RECEIVED BEFORE?  NO  YES: WHEN AND WHY? (include diagnoses, names of doctors, **dates**, and types of treatment)

HAS YOUR CHILD EVER BEEN HOSPITALIZED FOR A MENTAL HEALTH PROBLEM?

NO  YES REASON(S) AND **DATES:** \_\_\_\_\_

PRESENT COUNSELOR/THERAPIST? \_\_\_\_\_ NO : \_\_\_\_\_ YES IF YES: NAME AND **DATE(S) SEEN:** \_\_\_\_\_

PAST COUNSELOR/THERAPIST(S): \_\_\_\_\_ NO \_\_\_\_\_ YES, IF YES, NAME **DATE(S) SEEN :** \_\_\_\_\_

**PRESENT PSYCHIATRIST(S):** \_\_\_\_\_ NO \_\_\_\_\_ YES IF YES, NAME **DATES(S) SEEN:** \_\_\_\_\_

PAST PSYCHIATRIST: \_\_\_\_\_ NO \_\_\_\_\_ YES IF YES, NAME AND **DATES(S) SEEN:** \_\_\_\_\_

**PRESENT PSYCHIATRIC MEDICATION** (include mg): \_\_\_\_\_ NO: \_\_\_\_\_ YES IF YES: NAME: \_\_\_\_\_

PAST PSYCHIATRIC MEDICATION (include mg): \_\_\_\_\_ NO \_\_\_\_\_ YES IF YES: NAME: \_\_\_\_\_

## RISK BEHAVIOR

HAS YOUR CHILD EVER THREATENED TO HARM HIM/HERSELF?  NO  YES IF YES, PLEASE

## CHILD QUESTIONNAIRE

GIVE DATES/DETAILS: \_\_\_\_\_  
\_\_\_\_\_

HAS YOUR CHILD EVER ATTEMPTED TO HARM HIM/HERSELF?  NO  YES IF YES, PLEASE GIVE

DATES AND DETAILS: \_\_\_\_\_  
\_\_\_\_\_

HAS YOUR CHILD EVER THREATENED/ATTEMPTED TO HARM OTHERS?  NO  YES IF YES, PLEASE GIVE  
DATES/DETAILS:

\_\_\_\_\_  
\_\_\_\_\_

### FAMILY MENTAL HEALTH HISTORY

FAMILY MEMBERS WITH HISTORY OF PSYCHIATRIC OR EMOTIONAL PROBLEMS: (please list name, relationship to you, type of problem, any treatment received)

\_\_\_\_\_  
\_\_\_\_\_

FAMILY MEMBERS WITH HISTORY OF LEARNING PROBLEMS: (please list name, relationship to you, type of problem, any treatment received)

\_\_\_\_\_  
\_\_\_\_\_

FAMILY MEMBERS ON PSYCHIATRIC MEDICATION: (please list name, relationship to you, type of medication)

\_\_\_\_\_  
\_\_\_\_\_

FAMILY MEMBERS WITH HISTORY OF DRUG/ALCOHOL ABUSE: (please list name and relationship)

\_\_\_\_\_  
\_\_\_\_\_

### ALCOHOL/SUBSTANCE ABUSE HISTORY

IS THE CHILD CURRENTLY USING ILLICIT DRUGS (not prescribed for the child):

NO  YES IF YES, STATE WHICH DRUGS (if known) AND DATES OF USE: \_\_\_\_\_  
\_\_\_\_\_

HAS THE CHILD USED ILLICIT DRUGS IN THE PAST (not prescribed for the child):

NO  YES IF YES, STATE WHICH DRUGS (if known) AND DATES OF USE \_\_\_\_\_  
\_\_\_\_\_

### PHYSICAL HEALTH HISTORY

What is your child's current physical health status? \_\_\_\_\_ Excellent \_\_\_\_\_ Fair \_\_\_\_\_ Poor

## CHILD QUESTIONNAIRE

If not excellent, please explain: \_\_\_\_\_

Has your child **had physical health exam** in the past 6 months?  NO IF YES, GIVE DATE: \_\_\_\_\_

**Vision/Eye exam?**  NO IF YES, GIVE DATE: \_\_\_\_\_

**Hearing Test?**  NO IF YES, GIVE DATE: \_\_\_\_\_

LIST WITH **DATES** OF MAJOR ILLNESSES/INJURIES/ACCIDENTS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

PHYSICAL HEALTH MEDICATIONS CURRENTLY BEING TAKEN: \_\_\_\_\_

MEDICATIONS TAKEN IN THE PAST: \_\_\_\_\_

HOSPITALIZATIONS/SURGERIES (list hospital, **dates**, and doctors): \_\_\_\_\_

## SCHOOL INFORMATION

PRESENT GRADE LEVEL (1<sup>ST</sup>, 3<sup>RD</sup>, 8<sup>TH</sup>, 10<sup>TH</sup>, etc): \_\_\_\_\_ MARKS LAST REPORT CARD (A's, B's, etc.)

IF MARKS ARE POOR OR FAILING (D'S/F'S), WHY? \_\_\_\_\_

NAME OF SCHOOL: \_\_\_\_\_

### CLASS PLACEMENT (Check all that apply):

REGULAR CLASSES ONLY

REGULAR CLASSES WITH CONTENT RESOURCE (if so, which subjects): \_\_\_\_\_

HEARING IMPAIRED       DEVELOPMENTALLY HANDICAPPED       VOCATIONAL

SEVERE BEHAVIOR HANDICAP       MULTI-HANDICAPPED

OTHER: \_\_\_\_\_

RETENTIONS?  NO  YES IF YES, WHICH GRADE(S) WERE REPEATED? \_\_\_\_\_

REASON(S) FOR RETENTION: \_\_\_\_\_

TRUANCIES?  NO  YES IF YES, GIVE DATES/REASONS \_\_\_\_\_

## CHILD QUESTIONNAIRE

SUSPENSIONS OR EXPULSIONS?  NO  YES IF YES, GIVE DATES/REASON(S) \_\_\_\_\_

### WORK HISTORY (if any)

- CHILD HAS NEVER WORKED OUTSIDE THE HOME
- CHILD HAS WORKED OUTSIDE THE HOME: (please provide dates/details) \_\_\_\_\_

### LEGAL HISTORY

HAS YOUR CHILD EVER BEEN ARRESTED?  NO  YES IF YES, PLEASE GIVE DETAILS OF CHARGE(S),  
DATE(S) OF ARREST, AND OUTCOME(S): \_\_\_\_\_

HAS YOUR CHILD EVER BEEN INVOLVED WITH THE JUVENILE COURT?  NO  YES

IF YES, PLEASE GIVE **DATES**/DETAILS BELOW: \_\_\_\_\_

### SOCIAL RELATIONS

HOW DOES YOUR CHILD GET ALONG WITH TEACHERS? \_\_\_\_\_

CLASSMATES? \_\_\_\_\_

PEERS OUTSIDE OF SCHOOL? \_\_\_\_\_

HOW DOES YOUR CHILD GET ALONG WITH ADULTS OUTSIDE OF SCHOOL? \_\_\_\_\_

HOW DOES YOUR CHILD RELATE TO PARENTS/CAREGIVERS? \_\_\_\_\_

SIBLINGS? \_\_\_\_\_

MY CHILD'S STRENGTHS: \_\_\_\_\_

MY CHILD'S RECREATIONAL INTERESTS \_\_\_\_\_

**OTHER INFORMATION THAT IS IMPORTANT TO KNOW ABOUT YOUR CHILD? PLEASE USE OTHER SIDE OF PAGE TO PROVIDE MORE INFORMATION. THANK YOU.**