



Living Life Counseling Center Child Questionnaire

(Parents please complete for children under 14 years of age)

Patient Name: _____ Age _____ DOB: _____ Date: _____

Telephone no: (Home) _____ (Work) _____ (Cell) _____

Legal Guardian Name: _____ Relationship to Patient: _____

Emergency Contact Information: Name: _____

Relationship _____ Telephone No: _____

Home Phone #: _____ Work Phone #: _____

Please state in your own words why you have come to today:

History of Present Illness: *(How long has this particular issue been going on):*

Sleep Disturbance Yes No (if yes please describe)

Appetite Changes Yes No (if yes please describe)

Psychiatric History:

I have received treatment for: Substance abuse Mental health issues Both

The treatment occurred at:

- Other private psychiatrist Mental Health Center
 Hospital Other counseling service Other facility

If hospitalized, please list dates and where hospitalized _____

Are you presently being treated? Yes No If yes, by whom? _____

Are you currently being prescribed psychiatric medications? Yes No

If Yes, please list **Current Psychiatric** medications _____

Psychological Testing:

Have you ever had psychological testing done in the past? Yes No

If yes, When _____ and by Whom _____

Medical History:

Name of your primary care doctor _____

Phone: _____ Date last seen: _____

Do you have a history of any medical problem? Yes No If so, what? _____

Are you presently being treated for any medical problem? Yes No If so, what?

Please list any current **Non-Psychiatric Medications** _____

- | | | |
|---|------------------------------|-----------------------------|
| Have you ever been treated for a nutritional problem? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you make yourself sick because you feel uncomfortably full? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you worry you have lost control over how much you eat? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you recently lost more than 14 pounds in a 3 month period? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you believe yourself to be fat when others say you are too thin? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would you say that food dominates your life? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Are you experiencing any physical pain? Yes ___ No ___

Family Psychiatric/Medical History: (Please list any familial psychiatric or major medical problems)

Social History: (Who does child live with, please state if parents are divorced and share custody also list any friends or outside supports)



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Developmental History:

Your child's weight at birth: _____ lbs. _____ oz. Was this a full term birth? Yes No
If no, explain:

Did either parent use drugs or alcohol at the time of conception? Yes No

Were there any complications with the labor & delivery such as jaundice, infection etc.? Yes No
If yes, explain:

Did child meet all developmental milestones on time? Yes No

If No please explain _____

Educational/Occupational

Most Recent Grade Completed: _____

Name school currently attending _____

Recent Report Card Grades _____

IEP/504 Yes No (if yes please explain why) _____

Behavioral Problems:

Has child ever had in or out of school suspension? Yes No (if yes please explain why)

Has child ever had problems with bullying? Yes No (if yes please explain)

Military Dependent: Yes No

Spiritual/Religious Affiliation

Attends church Yes No If Yes where _____

History of Legal Problems No Yes (if yes please explain:)

History of trauma? *(To include abuse, domestic violence, witnessing of; and military trauma):*

No Yes **(If yes please explain):**

Thank you for your cooperation and patience. Our clinician will see you shortly and discuss these and other issues in greater detail and help you develop a treatment plan to effectively deal with these issues.