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Tween/Teen History Questionnaire

Date questionnaire completed: _________
Name of person completing this form: ______________________________________
Relationship to child: ____

Name: ____
Age: _____________________ Birth date: ___________________________

Referral Information

Did someone refer you? If so, who? _______________________________________
Main Concerns: ____
____
____
____

Behavior Triggers: ____
____
____
____

When did you first notice the problem? ___________________________________
____

Describe impact of problem behaviors on familial, social, and academic functioning.
____
____
____
____

List any previous therapy or psychiatric consultation or treatment.

Provider name: ____

Dates of treatment: ____

Previous diagnoses: ____

Was it helpful? Why or Why not? ________________________________

____

Has the child undergone psychological testing? _________

(If so, please attach copy of evaluation report.)

Health Information

Was child adopted? _____ Date of adoption: ________ Age at adoption: ________

Is the child a twin/multiple? ________ Identical? ________

Duration of pregnancy: ________ Drug/alcohol use during pregnancy? ________

Was prenatal care provided during pregnancy? ________

Was delivery in a hospital? ________ C-section? ________

Describe any complications of pregnancy or delivery.

____

____

Suspected or confirmed child abuse (physical or sexual): ___________________

____

Name of pediatrician/PCP: ______________________________________

Phone number: ___________________________

Please indicate all medications and dietary supplements currently taken.

<u>Medication and dosage</u> <u>Diagnosis</u> <u>Prescribing physician</u> <u>Date of initial prescription</u>

____

____

____

____

Were the child's developmental milestones within normal limits? ________________

____

Does child have any illnesses? ____

____

Any eating or sleeping problems? ____

____

School Information

Name of school: ____

Grade: ________________________

Teacher: _______________________________

Does the child currently have a 504 Plan? _________ Diagnosis: _________________

504 Plan accommodations: _______________________________________

Does the child currently have an Individualized Education Plan (IEP)? ___________

Date of most recent IEP: __________

Educational disability: _________________________

Special education services received: _________________________________

Do the educational accommodations/services provided seem to be effective? _________

If no, please explain:

____

Ever held back a grade or skipped ahead? ___________________________________

____

Any concerns at school? ____

____

When did the problem begin? ____

What do teachers and others at the school tell you about the problem?

____

____

What has the school done to help? Has it been helpful? ________________________

____

Social/Emotional/Behavioral Functioning

Please indicate with an "X" if the child is currently struggling in any of the following areas.

Social

☐ Avoids eye contact

☐ Does not understand teasing, sarcasm, or jokes

☐ Does not speak/is selectively mute

☐ Isolated from peers – few group or social interactions

☐ Misinterprets facial expressions, body language, or tone of voice

☐ Struggles to maintain conversation

☐ Struggles to make or maintain friendships

☐ Teases or bullies others

☐ Victim of teasing or bullying

☐ Other Please Specify: ____

Emotional

☐ Cries easily or often

☐ Depressed/appears depressed

☐ Excessively afraid

☐ Excessively angry

☐ Expresses specific fears

☐ Expresses suicidal or homicidal ideation, plan, or intent

☐ Flat affect

☐ Gives up easily when challenged

☐ Rigid thinking (when things do not go as planned or "the right way," etc.)

☐ Other Please Specify: ____

Behavioral

☐ Difficulty focusing

☐ Difficulty initiating/starting tasks

☐ Displays attention-seeking behaviors

☐ Engages in risky behaviors

☐ Excessively fidgety

☐ Impulsive (acts before thinking)

☐ Interrupts others

☐ Oppositional/refuses to comply with requests

☐ Poorly organized

☐ Other Please specify: ____

Family/Home Environment

Please list all people living in the child's home.

Name	Relationship	Age	Occupation/Grade

Education Level: Mother ____________________ Father_____________________

Occupation: Mother_________________________ Father_____________________

Is either parent deceased? _________ If so, please specify: _________________

Were biological parents married? _________

Are biological parents separated or divorced? __________________

Date of separation or divorce: _________

Which parent has legal custody? __________________

Which parent has physical custody? __________________

Describe physical custody arrangement. ______________________________

____

____

How long has the child lived at the current address? _________________________

Does the child have any difficulty with siblings? _________

If yes, please explain: ____

____

Family History

Please indicate whether any of the following are currently being experienced within the immediate family.

☐ Birth of new child

☐ Death in family

☐ Domestic violence

☐ Employment loss

☐ Financial difficulties

☐ Marital difficulties

☐ Recent move

☐ Separation/divorce

☐ Serious illness

☐ Single parent/caregiver

☐ Other: _____________________________

Please indicate which of the following have been experienced in members of the child's immediate and/or extended family.

Relationship to Child (maternal/paternal)

☐ AIDS ____

☐ Alcoholism ____

☐ Anxiety ____

☐ ADHD/ADD ____

☐ Autism Spectrum Disorder ____

☐ Bipolar Disorder ____

☐ Birth Defects ______________________________

☐ Cancer ______________________________

☐ Depression ______________________________

☐ Diabetes ______________________________

☐ Drug Addiction ______________________________

☐ Eating Disorder ______________________________

☐ Heart Disease ______________________________

☐ High Blood Pressure ______________________________

☐ High Cholesterol ______________________________

☐ Intellectual Deficiency ______________________________

☐ Learning Disability ______________________________

☐ Psychiatric Hospitalizations ______________________________

☐ Suicide ______________________________

(threats, attempts, completed)

☐ Other (specify: __________) ______________________________

Additional Comments

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Thank you for taking the time to complete this questionnaire thoroughly!