Client Questionnaire Ages 6 – 10

The client's full legal name (first, middle, last) _____

What does the client prefer to be called? _____

Your name and relationship to the client: _____

The name and contact information for your child's teacher _____

BIRTH AND DEVELOPMENTAL HISTORY:

1. How many weeks gestation was the pregnancy? _____
2. Fetal Alcohol exposure? YES / NO (circle one)
    a. If Yes, how much and how often? _____

    _____
3. Fetal Drug Exposure? YES / NO (circle one)
    a. If Yes, how much and how often? _____

    _____
4. Normal labor and delivery? YES / NO (circle one)
    a. If No, describe medical interventions needed at birth. _____

    _____

    _____

    _____
5. Did the client remain in the hospital for a normal amount of time following their delivery (i.e. 2-3 days for vaginal delivery, 4 days for C-section)? YES / NO
    a. If No, described why they were required to stay in the hospital. Did this include a visit to the NICU? _____

    _____
6. The age of the client then they first:

a. Walked without holding on to anything? _____

b. Spoke first words, **NOT** mama or dada? _____

c. Said 2-3 word phrases? (i.e. "want juice", "go car") _____

d. Potty trained _____

i. Are there issues with incontinence (i.e. accidents) now? YES / NO

1. If yes, how often and when did they begin? _____

_____

7. How did the client interact with other children early in development? _____

_____

8. Did doctors (**pediatrician** or **other health care providers**) have concerns about the client's development? YES / NO

a. If yes, please describe the concerns. _____

_____

_____

PERSONAL HISTORY:

1. Place of birth? (City, State) _____
2. Where does your child currently live? (City, State) _____
3. Did the family live any other places between where the client was born and where they currently live now? YES / NO (circle one)

a. If yes, please list the places and dates. _____

_____

b. If moved, when was the move to the current home? _____

_____

4. With whom does the client live at present? (names, ages, relationship to the client)

_____

_____

5. How many siblings does the client have? Please list (i.e. stepsister, maternal half sister, etc. AND the ages.) _____

   _____

   _____

6. Who primarily raised the client? Please describe any changes in caregivers and reasons for the changes. _____

   _____

   _____

7. Does the other parent know their child is currently undergoing psychological testing? YES / NO (circle one)

   a. Please list any important custody issues. _____

      _____

      _____

8. If your child does not have contact with one parent, has there ever been a relationship with this individual? YES / NO (circle one)

   a. If so, when did contact end and why? _____

   _____

   _____

   _____

   _____

9. *Has your child ever been removed from the custody of primary caregivers (i.e. by DHS)? YES / NO (circle one)

a. If so, why and for how long? _____

_____

_____

_____

10. *Has your child ever had to live with other family members or caregivers? YES / NO (circle one)

a. If so, why and for how long? _____

_____

_____

_____

11. *Has your child witnessed domestic violence in the past? YES / NO (circle one)

12. *Does your child have a history of physical, sexual, or verbal abuse? YES / NO (circle one)

13. What languages are spoken in the home? _____

a. If a language other than English is spoken in the home, which language is your child most fluent in? _____

b. What is your child's preferred language (if multiple languages are spoke in the home) ? _____

c. Which language was your child first exposed to? _____

d. How did your child come to learn English if they have? _____

_____

14. Does the family have any religious affiliations? YES / NO (circle one)

a. If so, how often do you attend services or activities related to your faith and religion? _____

15. What activities do the family complete together? _____

_____

MEDICAL HISTORY:

1. Does your child have any significant **MEDICAL** (not psychological) issues at the present time? YES / NO (circle one)
    a. If so, please provide the diagnosis, date diagnosed, the person who diagnosed them, and treatment provided _____

_____

_____

_____

2. Has your child undergone **genetic** testing in the past? YES / NO (circle one)
    a. If yes, please explain the findings _____

_____

3. Is there a history of surgeries? YES / NO (circle one)
    a. If yes, please list the dates and types of surgeries, and the doctor or practice who performed the surgery. _____

_____

4. Is there a family history of medical and genetic disorders **NOT psychological disorders** (i.e. Huntington's disease, Down's syndrome, hypothyroidism, etc.) YES / NO (circle one)
    a. Please list along with the relationship of the family member.

_____

_____

_____

5. *Is there a history of concussions, seizures, comas, or significant head injuries? YES / NO (circle one)
    a. If your child has a history of significant head injuries or concussions, when did they occur and who diagnosed the concussion? _____

       _____
    b. If your child has a history of seizures, when was the last seizure? _____

       _____
    c. When was your child's first seizure? _____
    d. Has your child ever lost consciousness during a seizure? YES / NO (circle one)
6. Please list the primary care physician and the name of the practice.

   _____

   _____
7. Please list the name of the psychiatrist (they ONLY prescribe medication, they do not do therapy). _____
8. Please list prescribed medications your child currently takes:
    a. Medication name: _____
        i. When prescribed: _____
        ii. How much/how often: _____
        iii. Side effects: _____
        iv. Prescribed for (i.e. depression): _____
    b. Medication name: _____
        i. When prescribed: _____

ii. How much/how often: _____

iii. Side effects: _____

iv. Prescribed for: _____

c. Medication name: _____

i. When prescribed: _____

ii. How much/how often: _____

iii. Side effects: _____

iv. Prescribed for: _____

d. Medication name: _____

i. When prescribed: _____

ii. How much/how often: _____

iii. Side effects: _____

iv. Prescribed for: _____

9. Please list any **over-the-counter** medications/**supplements**:

a. Medication name: _____

i. When began: _____

ii. How much/how often: _____

iii. Side effects: _____

iv. Used for: _____

v. Has your child's doctor been told about these? YES / NO (circle one)

b. Medication name: _____

i. When began: _____

ii. How much/how often: _____

iii. Side effects: _____

iv. Used for: _____

v. Has your child's doctor been told about these? YES / NO (circle one)

10. Have any other medications been prescribed and discontinued within the past year? YES / NO (circle one)

    a. If yes, please list : _____

11. Has your child ever failed a hearing test? YES / NO (circle one)

    a. When was the last hearing test? _____

12. Does your child have a history of chronic ear infections? YES / NO (circle one)

    a. If yes, how frequent were the ear infections? _____

    _____

    b. How were they treated? _____

    _____

    c. Did you notice any changes once the ear infections were resolved? YES / NO (circle one)

        i. Please list those changes: _____

    _____

13. Does your child have a history of vision issues? YES / NO (circle one)

    a. If yes, does your child have a prescription for glasses? YES / NO (circle one)

    b. When were they prescribed? _____

    c. Does your child wear the glasses regularly? _____

14. When was the last eye exam? _____

15. How many hours of sleep does your child receive per night? _____

16. Does your child have any difficulties with sleep? YES / NO (circle one)

    a. If yes, please describe: _____

       _____

       _____

    b. If your child has difficulty sleeping, how many nights per week does this occur? _____

    c. How do the sleep difficulties impact your child? _____

       _____

    d. Does your child still wake rested in the morning? _____

    e. When did these sleep difficulties begin? _____

    f. Any history of nightmares/night terrors? YES / NO (circle one)

        i. If yes, when did these begin? _____

        ii. What time of night do they occur? _____

17. Has your child ever participated in any of the following:

    a. Speech therapy - YES / NO (circle one)

        i. Is your child currently in treatment? YES / NO (circle one)

        ii. When did treatment begin? _____

        iii. How long did treatment last? _____

        iv. How often is/was treatment? _____

        v. Where is/was treatment? _____

        vi. What was the focus of treatment? _____

            _____

b. Occupational therapy - YES / NO (circle one)

   i. Is your child currently in treatment? YES / NO (circle one)

   ii. When did treatment begin? _____

   iii. How long did treatment last? _____

   iv. How often is/was treatment? _____

   v. Where is/was treatment? _____

   vi. What was the focus of treatment? _____

   _____

c. Physical therapy - YES / NO (circle one)

   i. Is your child currently in treatment? YES / NO (circle one)

   ii. When did treatment begin? _____

   iii. How long did treatment last? _____

   iv. How often is/was treatment? _____

   v. Where is/was treatment? _____

   vi. What was the focus of treatment? _____

   _____

d. Applied Behavioral Analysis (ABA) therapy - YES / NO (circle one)

   i. Is your child currently in treatment? YES / NO (circle one)

   ii. When did treatment begin? _____

   iii. How long did treatment last? _____

   iv. How often is/was treatment? _____

   v. Where is/was treatment? _____

   vi. What was the focus of treatment? _____

_____

SUBSTANCE ABUSE OR EXPOSURE:

1. Has your child been exposed to illicit substances in the home? YES / NO (circle one)
    a. If yes, please explain. _____

    _____

    _____
2. Does anyone in the home have a history of substance abuse? YES / NO (circle one)
    a. If yes, please explain _____

    _____
3. Has your child ever been administered CDB in any form? YES / NO (circle one)
    a. If yes, please explain _____

    _____
4. Does your child have a history of substance use? YES / NO (circle one)
    a. If yes:
        i. What type of substance? _____

        _____
        ii. How often? _____

        _____
        iii. Have you noticed changes in your child's functioning as a result of their use?

        _____

        _____

ACADEMIC HISTORY:

1. What school does your child currently attend (if school is out of session, what school was recently attend)? _____
2. What grade is your child currently enrolled in (if school is out of session, what grade was recently completed)? _____
3. Please list the contact information for a teacher. _____

   _____
4. If your child is **NOT** currently in school:
   a. Who watches your child during the day? _____
   b. What does your child's daily routine consist of? _____

      _____

      _____

      _____
5. Has your child ever been suspended or expelled from school? YES / NO (circle one)
   a. If yes, please note the dates and the reasons given for these punishments.

      _____

      _____

      _____

      _____
6. Has your child ever been held back a grade? YES / NO (circle one)
   a. If yes, please explain what grade and the reason for being held back? ___

      _____

      _____

      _____

7. Does your child have an IEP or 504 Plan at present? YES / NO (circle one)
    a. If so, what accommodations are outlined by these plans? If not, are there discussions to create an IEP or 504 Plan?_____

    _____

    _____
8. Does your child participate in special education classes? YES / NO (circle one)
    a. If so, how often and for what subject? _____

    _____

    _____

    _____
9. Please describe your child's grades and subjects your child struggles most.

    _____

    _____

    _____
10. Which subjects does your child perform well at? _____

    _____

    _____
11. What are the teachers' concerns? _____

    _____

    _____

    _____
12. How would you describe your child socially? Shy/Outgoing/Social/Withdrawn?

    _____

13. Does your child have a best friend? YES / NO (circle one)
    a. If yes, who is it? _____
14. Who does your child prefer to play with? _____
15. Does your child have consistent interactions with same aged peers? YES / NO (circle one)
    a. If no, who does your child play with? _____
    b. If yes, where does your child play with others (i.e. neighborhood, school, after-school activities, at friend's homes). _____

       _____
16. What kinds of activities does your child enjoy? _____

    _____

    _____

    _____
17. What activities does your child participate in outside the home? _____

    _____

    _____

    _____
18. What activities do you complete as a family in the home? _____

    _____
19. How long does your child spend on screens per day (i.e. phones, video games, computers, tablets)? _____

MENTAL HEALTH HISTORY:

1. Has your child ever had a history of suicidal thoughts? YES / NO (circle one)

a. If yes, when did these begin? _____

b. When did they last make a suicidal statement? _____

c. Has your child identified a way they would carry this action out? YES / NO (circle one)

d. Do you have any concerns for the safety of your child? YES / NO (circle one)

e. Does your child have access to medications, weapons, or other means to harm themselves? YES / NO (circle one)

i. If yes, have you made any attempts to secure these items? YES / NO (circle one)

2. Does your child have a history of self-harm or self-injurious behavior? YES/NO (circle one)

a. If yes, when was the last incident? _____

b. Does the behavior leave significant marks or bruises? YES / NO (circle one)

c. When did these behaviors begin? _____

d. Is there anything that triggers the behavior? _____

_____

3. Does your child have a history of homicidal thoughts? YES / NO (circle one)

4. Does your child have a history of aggression towards others? YES / NO(circle one)

5. Has your child ever been hospitalized in an inpatient psychiatric facility? YES / NO (circle one)

a. If yes, what was the name of the facility? _____

_____

b. How long was your child hospitalized? _____

c. What diagnoses were assigned during the stay? _____

_____

_____

d. What kind of treatment was given? _____

_____

_____

_____

6. *Has your child ever mentioned that they saw things or heard things that others did not see or hear? YES / NO (circle one)

   a. If yes, when do these occurrences happen most often? _____

   _____

7. Is your child currently in mental health treatment? YES / NO (circle one)

   a. With whom and for how long? _____

   _____

   _____

   b. What was the focus of treatment? _____

   _____

   _____

   _____

   c. Was treatment helpful? Why or Why not?_____

   _____

   _____

8. List some of your child's strengths. _____

   _____

9. List some of your child's areas in need of growth. _____

   _____

10. What motivates your child? _____

    _____

    _____

11. If mental health treatment were recommended, what would you like to see addressed? _____

    _____

    _____

12. Please list any previous **MENTAL HEALTH** diagnoses assigned to your child. Please list who diagnosed the disorders and when.

    _____

    _____

    _____

13. Please circle any family history of the following **DIAGNOSED** mental health and neurodevelopmental disorders. Also specify who (as related to the child) was diagnosed:

    a. Depression

        i. Family member: _____

    b. Anxiety – Specify which type _____

        i. Family member: _____

    c. Bipolar Disorder

        i. Family member: _____

    d. Schizophrenia

        i. Family member: _____

e. Obsessive-Compulsive Disorder

    i. Family member: _____

f. Posttraumatic Stress Disorder

    i. Family member: _____

g. Personality Disorder- Specify which one _____

    i. Family member: _____

h. Learning Disorder

    i. Family member: _____

i. Intellectual Disability

    i. Family member: _____

j. Autism (or previous PDD or Asperger's Disorder)

    i. Family member: _____

k. Developmental Delays

    i. Family member: _____

l. Language Disorder

    i. Family member: _____

m. Learning Disorder - Specify which one _____

    i. Family member: _____

n. Attention Deficit Hyperactivity Disorder (ADHD)

    i. Family member: _____

o. Other: _____

    i. Family member: _____

CURRENT/PAST CONCERNS: Please circle if any of the following have been an area of concern in the past and briefly describe it:

History of trauma _____

_____

_____

_____

Depression _____

_____

_____

_____

Learning issues _____

_____

Anxiety _____

_____

_____

_____

Relationships _____

_____

_____

_____

Development _____

_____

_____

_____

Self-harm _____

_____

_____

_____

Concerning behaviors _____

_____

_____

_____