Canyon Hills Counseling, LLC

Make Life Beautiful Again

CHILD & ADOLESCENT NEW CLIENT QUESTIONNAIRE

(Please Print)

Today's date:				
CLIENT INFORMATION				
Last name:	**First name:**	**Middle name:**	**Birth date (mm/dd/yy):**	**Age:**
Street address:	**City:**		**State:**	**Zip:**
Primary Phone No.:	**Secondary Phone No.:**			
Email:				
Ethnicity:	**Religious background/involvement:**			
Current School Name:	**Grade:**			
Please describe your current living arrangement:				

DEVELOPMENT

Are there special, unusual, or traumatic circumstances that have affected your child's development? _____ Yes _____ No

If yes, please describe: _____

_____

Has there been a history of child abuse? _____ Yes _____ No

If yes, which type(s)? _____ Sexual _____ Physical _____ Verbal

If yes, the abuse was as a: _____ Victim _____ Perpetrator

Other childhood issues: _____ Neglect _____ Malnutrition _____ Other (please specify):

Comments regarding childhood development: _____

_____

PHYSICAL

Date of most recent physical examination? _____ Results? _____

_____

_____

Current prescribed medications:

Name	Dose	Dates	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Current over-the-counter medications:

Name	Dose	Dates	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is your child allergic to any medications? _____ Yes _____ No

If yes, please describe: _____

SOCIAL RELATIONSHIPS

How does your child generally get along with other people? (check all that apply)

_____ Affectionate _____ Aggressive _____Avoidant _____Fight/argue often _____ Follower

_____ Friendly _____ Leader _____ Outgoing _____ Shy/withdrawn _____ Submissive

Other (specify): _____

Does your child have any history as a perpetrator of sexual abuse? _____ Yes _____ No

If yes, please describe: _____

LEGAL

Is your child involved in any active court cases (traffic, civil/domestic, criminal)? _____ Yes _____ No

If yes, please describe and indicate the court and hearing/trial dates and charges: _____

_____

Is your child currently on probation? _____ Yes _____ No

If yes, please describe: _____

Previous legal history (arrests, jail/prison, DUI/DWI, tickets)?:

_____

_____

BEHAVIORAL/EMOTIONAL

Has your child ever participated in therapy before? _____ Yes _____ No

If yes, when? _____ Reason? _____

Has your child ever seen a psychiatrist before? _____ Yes _____ No

If yes, when? _____ Reason? _____

Is your child currently seeing a psychiatrist? _____ Yes _____ No

If yes, for how long? _____ Reason? _____

Has your child or a family member ever been hospitalized for mental or emotional illness? _____Yes _____ No

If yes, please explain (dates, where, reason): _____

_____

Has your child or a family member ever been jailed or imprisoned for physical assaults or other behavior? _____Yes _____ No

If yes, please describe (dates, where, reason): _____

_____

Is your child or family experiencing any current threats of significant loss or harm (illness, divorce, custody, job loss, protection orders, etc.)? _____Yes _____ No

If yes, please describe: _____

_____

Please check any of the following that are typical for your child:

Aggressive	**Gambling**	**Selfish**
Achohol problems	**Hallucinations**	**Separation anxiety**
Angry	**Head banging**	**Sets fires**
Anxiety	**Heart problems**	**Sexual addiction**
Attachment to dolls	**Hopelessness**	**Sexual acting out**
Avoids adults	**Hurts animals**	**Sick often**
Bedwetting	**Imaginary friends**	**Short attention span**
Blinking/jerking	**Impulsive**	**Shy/timid**
Bizarre behavior	**Irritable**	**Sleeping problems**
Bullies/threatens	**Lazy**	**Slow moving**
Careless/reckless	**Learning problems**	**Soiling sheets/underwear**
Chest pains	**Lies frequently**	**Speech problems**
Clumsy	**Listens to reason**	**Stealing**
Cyber addiction	**Loner**	**Stomach aches**
Defiant	**Low self-esteem**	**Suicidal threats**
Depressed	**Messy**	**Suicidal attempts**
Destructive	**Moody**	**Talks back**
Difficulty speaking	**Nightmares**	**Teeth grinding**
Dizziness	**Oppositional**	**Thumb sucking**
Drug dependence	**Overactive**	**Tics/twitches**
Eating disorder	**Overweight**	**Unsafe behaviors**
Excessive masturbation	**Panic attacks**	**Unusual thinking**
Expects to fail	**Phobias**	**Weight loss**
Fatigue	**Poor appetite**	**Withdrawn**
Fearful	**Psychiatric problems**	**Worries excessively**
Frequent injuries	**Quarrels frequently**	**Other**
Frustrated easily	**Sad**	

Briefly discuss how any of the above symptoms impair your child's ability to function effectively:

_____

_____

_____

_____

_____

CRISIS INFORMATION

Is your child exhibiting any current suicidal thoughts, feelings, or actions? _____Yes _____ No

If yes, please explain:

_____

_____

Is your child exhibiting any current homicidal thoughts or feelings, or anger control problems? _____Yes _____ No

If yes, please explain:

_____

_____

SUBSTANCE ABUSE HISTORY

	Method of use and amount	Frequency of use	Age at first use	Age at last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol	_____	_____	_____	_____	____	____	____	____
Barbiturates	_____	_____	_____	_____	____	____	____	____
Valium/Librium	_____	_____	_____	_____	____	____	____	____
Cocaine/Crack	_____	_____	_____	_____	____	____	____	____
Heroin/Opiates	_____	_____	_____	_____	____	____	____	____
Marijuana	_____	_____	_____	_____	____	____	____	____
PCP/LSD/Mescaline	_____	_____	_____	_____	____	____	____	____
Inhalants	_____	_____	_____	_____	____	____	____	____
Caffeine	_____	_____	_____	_____	____	____	____	____
Nicotine	_____	_____	_____	_____	____	____	____	____
Over-the-counter	_____	_____	_____	_____	____	____	____	____
Prescription drugs	_____	_____	_____	_____	____	____	____	____
Other drugs/substances:	_____	_____	_____	_____	____	____	____	____
	_____	_____	_____	_____	____	____	____	____

TREATMENT NEEDS

How can I help? Please tell me in your own words what I can do to help your child:

_____

_____

_____

_____

What are your two most important goals for therapy?

1. _____

2. _____

OTHER

Is there any additional information that would assist me in addressing your concerns or problems with your child:

_____

_____

_____

_____