Yellowstone Counseling Center

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208 N. Broadway, Ste. 423 Billings, MT 59101
406-896-8427 fax 406-245-5980

CHILD/ADOLESCENT PSYCHOSOCIAL QUESTIONNAIRE

IDENTIFYING INFORMATION

Date of assessment:_____
Name of child: _____ Sex: M _____ F _____ Date of Birth _____
Place of birth: _____ Age: ____ Telephone: hm _____ wk _____ cell _____
Address: _____ City: _____ State: _____ Zip Code _____
Religion (optional): _____ School: _____ Grade: _____
Who referred you?: _____
Parent/Guardian: _____ Relationship: _____
Address (if different than above): _____ Phone: _____
Please list those who have legal custody: _____

I give permission for my child to be in counseling at the Yellowstone Counseling Center:

Parent/Guardian signature: _____ Date: _____

PRESENTING ISSUE(S)

What happened that makes you seek help at this time? _____
_____

How long have these problems occurred? (number of weeks, months, years) _____

Problems perceived to be: ___very serious ___serious ___not serious

Presenting Problems: (check all that apply)

___Impulsive	___Fire setting	___Irritable	___Self Harming	___Stealing	___Temper outbursts
___Lying	___School Performance	___Infantile	___Sexual trouble	___Hopelessness	___Mean to others
___Destructive	___Poor Concentration	___Worthlessness	___Guilt	___Fearful	___Trouble with the law
___Bed wetting	___Overactive	___Running away	___Soiled pants	___Shy	___ Sleeping problems
___Depression	___Head banging	___Distractible	___Uses drugs	___Lacks initiative	___Undependable
___Phobias	___Strange behavior	___Peer conflict	___Suicide talk	___Blames others	___Alcohol
___Nausea	___Strange thoughts	___Oppositional	___Sexual abuse	___Physical abuse	___Racing thoughts
___Stress	___Appetite disturbance	___Anxiety/Panic	___Rocking	___Withdrawn	

___Unpleasant thoughts that won't go away

Has this child/adolescent ever seen a mental health counselor before? ___ Yes ___ No If yes, when?_____
Please describe: _____

Is this child in a therapy program at school? _____ Yes_____ No

Does this child attend a school participating in Comprehensive School & Community Treatment Programs (CCST)? _____ If so, authorization may be required from insurance company.

What are your expectations of your child/adolescent?_____
_____

What changes would you like to see in your child/adolescent?_____
_____

What changes would you like to see in yourself? _____
_____

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What changes would you like to see in your family?_____

_____

PSYCHOSOCIAL HISTORY

CURRENT FAMILY SITUATION

Mother - Name_____
Relationship to child: _____natural parent _____relative _____step parent _____adoptive parent
Occupation _____ Age _____
Education _____ Religion _____
Birthplace _____ Birthdate _____

Father-Name_____
Relationship to child : _____natural parent _____relative _____step parent _____adoptive parent
Occupation _____ Age _____
Education _____ Religion _____
Birthplace _____ Birth date _____

Marital Status of Parents: Natural Parents: _____ married; when _____ ages _____
____separated; when _____ _____ divorced; when _____
____deceased Mother or Father If so, whom _____ Step-parents married; when _____
Is the child/adolescent adopted? ____ Adoption source: _____ Date of adoption:_____

LIVING ARRANGEMENTS

Does the child share a room with anyone else? _____Yes _____No

If yes, with whom? _____

If no, how long has he/she had own room? _____

Was the child ever placed, boarded, or lived away from the family? _____ Yes _____No

Explain: _____

What are the major family stresses at the present time, if any? _____

_____

Number of moves in child's life (please include places and dates): _____
_____

BROTHERS and SISTERS (indicate if step-brothers or step-sisters) Please list all siblings, their names, ages, school or occupation, if living at home, whether any problems with alcohol or other drugs. _____
_____
_____

List all other extended family members by their relation to the patient who have drug and/or alcohol problems (legal or illegal), history of mental disorders, self-destructive behavior, or legal problems._____

_____

Others living in the home (and their relationship:_____

HEALTH OF FAMILY MEMBERS (excluding patient) Please list serious illnesses to any member of household.

_____

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Does or did any member of the child/adolescent's family have any problems with: _____ reading _____ spelling _____ math _____speech (if yes, please explain): _____

CHILD HEALTH INFORMATION
Note all health problems the child/adolescent **has had in the past – put "P" on line** or **currently has – put "C" on the line**.

___High fevers	___Dental problems	___Pneumonia	___Weight problems	___Flu
___Hearing problems	___Encephalitis	___Skin problems	___Meningitis	___Asthma
___Convulsions	___Accident prone	___Stomach problems	___Concussions	___Headaches
___Head injury	___Sinus problems	___Tonsils out	___Anemia	___Dizziness
___Heart problems	___Vision problems	___Earaches	___Fainting	___Allergies
___Hyperactivity	___High/low blood pressure			

___Other illnesses, etc. : (Explain) _____

Has the child/adolescent ever been hospitalized? _____Yes _____No If yes, please explain: _____
_____

Has child/adolescent ever taken, or is she/he presently taking any prescribed medications? _____Yes _____No Please list the names of the medications along with prescribed dosages: _____
Age _____ How Long _____ Reason _____
Name of Primary Care Physician _____ Date last seen_____

DEVELOPMENTAL HISTORY
Prenatal--Child wanted? ____Yes ____No Planned for? ____Yes ____No Normal pregnancy? ____Yes ____No
If mother was ill or upset during pregnancy, explain:_____
Length of pregnancy: _____
Paternal support and acceptance: (explain)_____
BIRTH Length of active labor: ____hrs. Full term: ____Yes ____No If premature, how early?_____
If overdue, how late? _____
Birth weight: _____lbs. _____oz.
Type of delivery: _____spontaneous _____cesarean _____with instruments_____head first _____breech
Was it necessary to give the infant oxygen? _____Yes _____
Physical condition of infant at birth: _____
Please list any complications: _____
Did mother abuse alcohol/drugs during pregnancy? _____Yes _____No

NEWBORN PERIOD

		How long?
Irritability	___Yes ___No	_____
Vomiting	___Yes ___No	_____
Difficulty breathing	___Yes ___No	_____
Convulsions/twitching	___Yes ___No	_____
Colic	___Yes ___No	_____
Normal weight gain	___Yes ___No	_____
Breast fed	___Yes ___No	_____

Describe the manner in which toilet training was accomplished: _____
_____

DEVELOPMENTAL MILESTONES
Age at which child:
Sat up: _____ Crawled: _____
Walked: _____
Bladder trained: _____
Bowel trained: _____
Weaned: _____
Spoke single words: _____
Sentences: _____

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EARLY SOCIAL DEVELOPMENT

Relationship to siblings and peers: _____
Describe special habits, fears, or idiosyncrasies of the child: _____
_____

EDUCATIONAL HISTORY
Please lists names of schools and dates attended: _____
_____
Has this child/adolescent ever been diagnosed with a learning disability?_____
If yes, when and by whom?_____

Does this child/adolescent have any difficulties with school? _____

How would you describe your child/adolescent's academic strengths and weaknesses?_____

_____

Please describe present peer relationships: _____

_____

Has child/adolescent had special testing in school? Psychological _____Yes _____ No If so, when _____

Vocational _____Yes _____No If so, when_____

List child/adolescent's special interests, hobbies, skills: _____
_____
_____

Please describe any problems with the law: _____
_____

Please describe any employment experience: _____
_____