CONFIDENTIAL

Child and Adolescent History Questionnaire

DATE OF COMPLETION: (year/month/day) ____/____/____

Name: _____ Sex: ____M ____F Age: ____

Address: _____ Date of birth: (year/month/day) ____/____/____

_____ MHSC: (6 digit) _____

Postal Code: _____ PHIN: (9 digit) _____

Telephone: _____ (res) _____ (bus) Treaty #: _____

Family Doctor: _____ School: _____ Grade: ____

Parent(s)/Legal Guardian(s):

Mother: _____ Father: _____

Step-Mother: _____ Step-Father: _____

Other: _____

REASON FOR REFERRAL: What are your child's current problems? When did they begin? Has this problem changed with time?

(Please use reverse side if more space is needed)

Person(s) completing this form: _____

CHILD'S MEDICAL HISTORY:

Did/does your child have:	Yes	No
1. Early failure to gain weight	____	____
2. Seizures or convulsions	____	____
3. Meningitis or encephalitis	____	____
4. A skull fracture or unconsciousness after head injury	____	____
5. Lead poisoning	____	____
6. Bronchial asthma	____	____
7. **Allergies**	____	____
8. Diabetes	____	____
9. Other diseases	____	____
10. Has your child been hospitalized at any time	____	____

If yes to any of the above, please describe or give details:

_____

_____

_____

_____

_____

MEDICATION(S) - Past or present: (Please indicate medication, dosage, reason for taking, duration of treatment and side effects)

_____

_____

_____

Any problems with:	Yes	No		Yes	No
Vision	____	____	Coordination	____	____
Hearing	____	____	Appetite	____	____
Frequent headaches	____	____	Sleep	____	____
Other pains and aches	____	____	Other physical complaints	____	____
Any tics? (repetitive movements, ie. blinking, sniffing, clearing throat)				____	____

If yes to any of the above, please describe or give details:

_____

_____

_____

_____

Has your child had any past EMOTIONAL/BEHAVIOURAL/PSYCHIATRIC problems?
If yes, please describe or give details:

_____

_____

_____

FAMILY INFORMATION:

Are natural mother and father living together? Yes ____ No ____

If No, please indicate present living arrangements:

FAMILY	Name	Age	Occupation or Grade
Father			
Mother			
Siblings			
Relatives/Others			
(in the home)			

FAMILY MEDICAL HISTORY:

Any major medical problems in the family? **Yes** **No**

Father ..... ____ ____
Mother ..... ____ ____
Brothers and Sisters ..... ____ ____
Extended family of relatives ..... ____ ____

If yes to any of the above, please describe or give details:

Any psychiatric problems in family members, ie. depression, anxiety, attention deficit disorder, alcoholism, past or present? **Yes** **No**

Father ..... ____ ____
Mother ..... ____ ____
Brothers and Sisters ..... ____ ____
Extended family or relatives ..... ____ ____

If yes to any of the above, please describe or give details:

Any educational problems (learning disabilities) in family members? **Yes** **No**

Father ..... ___ ___
Mother ..... ___ ___
Brothers and sisters ..... ___ ___
Relatives or extended family ..... ___ ___

If yes to any of the above, please describe or give details:

RELATIONSHIPS: (How does the child get along with...)

Parents:

Brothers and Sisters:

Friends/Peers:

Are there any relatives or family friends special to the child?

DEVELOPMENTAL HISTORY:

PREGNANCY:

Did the mother have any of the following:	Yes	No
1. Pre-eclampsia or toxemia	____	____
2. High blood pressure	____	____
3. Vaginal bleeding in the first three months	____	____
4. Did the mother take vitamins and iron during pregnancy	____	____
5. Did the mother take any medications during the pregnancy	____	____
6. Did the mother smoke any tobacco during the pregnancy	____	____
7. Other drug/substance abuse	____	____
8. Did the mother drink alcohol in moderation during the pregnancy	____	____
9. Did the mother drink heavily during the pregnancy at any time	____	____
10. Did the mother experience emotional problems during the pregnancy	____	____
- or within six months following delivery	____	____
11. Was the pregnancy less than 35 weeks	____	____
- or more than 42 weeks	____	____
12. Any infections, ie. German measles, hepatitis B or Strep B	____	____
13. Any sexually transmitted diseases, ie. syphilis, gonorrhea or AIDS	____	____
14. Any other medical problems	____	____
15. Other complications of pregnancy, ie. abruptio placenta, placenta previa, etc.	____	____

If yes to any of the above, please describe or give details:

_____

_____

_____

_____

_____

_____

DELIVERY:

Did the mother have any of the following:	Yes	No
1. A labour under two hours or over 16 hours	____	____
2. Epidural	____	____
3. Other anesthesia or painkiller	____	____
4. Forceps	____	____
5. Breech or other difficult presentation	____	____
6. Induction of labour	____	____
7. Ceasarean section	____	____
8. Any other unusual problems during delivery	____	____

If yes to any of the above, please describe of give details:

_____

_____

_____

_____

_____

CHILD'S EARLY COURSE IN HOSPITAL:

	Yes	No
Actual birth weight: ____lbs ____oz or _____g		
Was your child's birth weight under 5 lbs, 8 oz (under 2.5 kg or 2500 g)	____	____
Did the child have trouble breathing at birth	____	____
Was the child placed in an incubator	____	____
Did the child have newborn jaundice	____	____
Did the jaundice require treatment	____	____
Any other trauma/illness/unusual events	____	____

If yes to any of the above, please describe or give details:

_____

_____

_____

_____

INFANCY/TODDLERHOOD: (Birth to 2 years)

Was the baby easy to settle? **Yes** ____ **No** ____

Any colic? **Yes** ____ **No** ____

What kind of baby was she/he? _____

At what age...

1. Did the baby sit without support? _____
2. Did the baby crawl? _____
3. Did the baby begin to walk? _____
4. Did the baby speak full sentences? _____
5. Was she/he potty trained? _____

If any problems above, please describe or give details:

_____

_____

_____

_____

PRESCHOOL YEARS: Did the child at age 2-5 years show any of the following?

	Yes	No		Yes	No
A short interest or attention span	____	____	Restlessness	____	____
Frequent temper outbursts	____	____	Hyperactivity	____	____
Destructive with toys or property	____	____	Frequent head-banging ..	____	____
Not wanting to be held or cuddled	____	____	Frequent rocking	____	____
Shy/not interested in playing with others	____	____	Nail-biting	____	____

If yes to any of the above, please describe or give details:

_____

_____

_____

_____

DEVELOPMENTAL DELAYS:

Did your child learn to:	Yes	No
1. Walk by 14 months	____	____
2. Speak single words by 14 months	____	____
3. Speak in sentences by 3 years of age	____	____
4. Complete toilet training before 3rd birthday	____	____
5. Ride a tricycle by the 3rd birthday	____	____

If no to any of the above, please describe or give details:

_____

_____

_____

_____

_____

At what age did the child become clearly right-handed _____ left-handed _____?

SCHOOL HISTORY:

Year	School	Location	Progress
Preschool			
K			
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Any additional information regarding the above:

_____

_____

_____

LEVELS OF SCHOOL SUCCESS:

Grade	Nursery	K	1	2	3	4	5	6	7	8	9	10	11	12
Above Average														
Average														
Below Average														

RELATIONSHIPS WITH OTHER CHILDREN:

	Yes	No
Does your child play with other children	____	____
Does your child play alone	____	____
Is the child involved in extracurricular activities, ie. music, 4H, sports	____	____
Does the child prefer to play with children of the same age	____	____

Additional information to the above:

_____

_____

_____

SOCIAL DIFFICULTIES:

Has the child been involved in any of the following behaviour(s)?

	Yes	No		Yes	No
Lying	____	____	Running away	____	____
Fighting	____	____	Destruction of property	____	____
Cruelty to animals	____	____	Alcohol abuse	____	____
Fire setting	____	____	Drug abuse	____	____
Stealing	____	____	Trouble with the law	____	____

If yes to any of the above, please describe or give details:

_____

_____

_____

ABUSE:

Has your child been the victim of abuse (physical, sexual, verbal, emotional or neglect)?

Yes ____ No ____

If Yes, please explain including information regarding any treatment received:

_____

_____

_____

_____ Revised 06/01

Any concerns about the child's sexuality, ie. behaviour, orientation, etc.?

_____

_____

_____

Any physical complaints (past or present) for which a doctor found no reason?

_____

_____

_____

Is the child affected by any physical condition/challenge?

_____

_____

_____

Any concerns about the child's eating behaviour, ie. excessive dieting, binge eating, etc.?

_____

_____

_____

Any concerns/problems with disciplining the child? What methods do you use?

_____

_____

_____

Did any important event concerning the your child and/or family occur within the last 6 (six) months? No ____

Death (who) _____

Separation/divorce _____

Serious accident (who) _____

Moving to a new place _____

Serious illness/hospitalization (who) _____

Close friend moved away _____

Loss of pet _____

Break up with romantic partner _____

Birth of sibling _____

Unemployment or other serious financial difficulty _____

Other _____

_____

PERSONALITY: Please check the personality characteristics which fit the child.

Moody		Underestimates her/his own abilities	
Confident		Emotional	
Shy		A leader	
Sociable		A hypochondriac	
Reliable		Good sense of humour	
Easily led - a follower		Conscientious	
Sad		Impulsive	
Has many fears		Underestimates her/his abilities	
Undisciplined		Worries a lot	
Likes to control		Fearless	
Religious		Always has to get her/his own way	
Feels sorry for her/himself		Likes to be the centre of attention	
Bad tempered		Preoccupied with sex	
Not active enough		Has chip on shoulder	
A loner		Talkative	
Cries a lot		Overestimates own abilities	
Is easily hurt by criticism		Has difficulty making decisions	
Very active		Constantly needs reassurance, approval and/or praise	
Mistrustful of people		Sulks when asked to do something she/he does not like to do	
A perfectionist		Overly concerned with physical attractiveness	
Has talked of suicide		Has attempted suicide	

PREVIOUS ASSESSMENTS: Please check all that apply:

Pediatric ____ Neurological ____ Genetic ____

Psychiatric ____ Mental Health Worker ____ Social Work ____

Psychological ____ Speech/Language ____ Educational ____

Forensic ____ Child Development Clinic ____ Other ____

Please provide details including: Dr. or Clinician.....Address.....What was done.....When.

(Please use reverse side if more space is needed)

SERVICES/AGENCIES INVOLVED WITH THE CHILD: (Past and Present)

Physician(s) ____
Child & Family Services ____
RCMP ____
Other hospital(s) or clinic(s) ____
Family Services ____
School Support Services ____
Group Home(s) ____
Courts/Probations ____
Child & Adolescent Treatment Centre, Brandon ____
Other _____

Please provide names, addresses, and date(s) of involvement:

Is the child aware of the referral? **Yes** ____ **No** ____

If Yes, what has the child been told and what is the child's response/feeling?

What are you hoping your child will receive from this assessment?

Thank you very much for your assistance in completing this questionnaire which is most important for a thorough and complete assessment of your child.