THERAPEUTIC SERVICES AGENCY, INC.

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CHILD/ADOLESCENT HISTORY QUESTIONNAIRE

Child's Name: _____Age: _____ Gender:_____Today's Date:_____

Date of Birth: _____Race:_____

Your Name: _____ Your Relationship to Child: _____

Address:_____ Phone:_____ Is it okay to leave a message? ___Yes ____No

_____ Phone: _____Is it okay to leave a message? ___Yes ____No

Emergency Contact:_____ Phone:_____Relationship:_____

Biological Father's Name: _____ Age: _____

Biological Mother's Name: _____ Age: _____

Parents' Current Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Never Married

Who has legal custody of the child? _____

Has your child ever lived with someone other than you? ☐Yes ☐No

Primary Household
(Who currently lives in the child's home?)

Name	Relationship to child	Age	Quality of relationship

If the child lives in more than one household please complete the secondary household information below.

Secondary Household

Name	Relationship to child	Age	Quality of relationship

Were you referred to TSA (if yes, who and for what reason)? _____

What led you to seek our services? _____

_____

_____

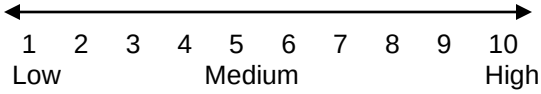
When did this problem begin? _____

How often does this problem occur?

O Daily O Some days
O Most days O Under certain circumstances

How severe is the problem now?

(on a scale 1 to 10; 1 is the lowest and 10 is highest)



Has this child experienced any of the following (please check)?

- ☐ **Previous mental health issues or evaluation**
- ☐ **Psychiatric hospitalization**
- ☐ **Prior mental health diagnosis**
- ☐ **Out of home placement**
- ☐ **Legal Issues**

Please describe any of the items endorsed above: _____

_____

_____

Family Concerns (please check if the following pertain to any of the child's family members)

- ☐ **Mental health issues**
- ☐ **Significant family disruption**
- ☐ **Alcohol abuse**
- ☐ **Substance Use**
- ☐ **Legal Issues**
- ☐ **Physical health concerns/disabilities**
- ☐ **Cognitive or learning disabilities**
- ☐ **Financial stressors**
- ☐ **Abuse Issues:**
  - ☐ **Victim**
  - ☐ **Perpetrator**

Please describe any of the items endorsed above: _____

_____

_____

Developmental Issues

Prenatal/Birth History	**Yes**	**No**	**Unknown**
Birth mother used alcohol, tobacco, and/or nonprescription drugs while pregnant			
Birth mother was depressed during the pregnancy			
Birth mother used alcohol, tobacco, and/or nonprescription drugs while pregnant			
Birth mother was under stress or was a victim of abuse during the pregnancy			
Birth mother had medical complications during the pregnancy			
Birth mother had medical complications during labor and/or delivery			
Birth father had health problems or was under stress during pregnancy			
Child was oxygen-deprived or had breathing-related problems during/after birth			
Child had other significant medical problems at birth			

Child's Early Development (did the child have any of the following before age 3)	**Yes**	**No**	**Unknown**	**Onset**
Feeding problems				
Sleeping problems				
Colicky or excessively fussy				
Slow in learning to roll over, sit up, crawl, or walk				
Slow in learning to use fingers to pick things up, stack blocks, use crayons, etc.				
Slow in learning to understand the speech of others				
Slow in learning to talk				
Slow in learning self-help skills (eating with a spoon, dressing, brushing teeth)				
Slow in learning colors, numbers, etc.				
Poor social interaction with other children (e.g. would fight often or play alone)				
Weak, inconsistent, or indiscriminant emotional attachment to caregivers				
Excessive emotional attachment to caregivers (clingy, had separation anxiety)				
Failure to seek out caregiver when distressed				
Engaged in self-harm behaviors (head banging, scratching, etc) when distressed				
Failure to form normal social relationships (poor eye contact, not socially alert)				
Unusual interests or play activities (preoccupied with spinning objects, patterns)				
Unusual bodily movements (e.g. hand-flapping) or speech mannerisms				
Childhood Health Issues (Does the child have a history of any of the following)	**Yes**	**No**	**Unknown**	
Frequent ear infections requiring prescription medication				
Seizures				
Head injury				
Asthma				
Trouble with hearing				
Trouble with vision				
Bedwetting after age 5				
Bowel-control accidents (soiling) after age 4				
Lead poisoning				
Cancer				
Major illnesses of hospitalizations				
Prescribed medication to treat a medical problem				
Child's current primary care physician/clinic is:_____	**n/a**	**n/a**	**n/a**	**n/a**
Would you like information to be shared with your primary care physician?			**n/a**	**n/a**
Functioning	**Yes**	**No**	**Unknown**	**If yes, still occurring?**
Poor appetite				
Constipation				
Stomachaches				
Trouble falling asleep				
Trouble staying asleep				
Over activity				
Head banging				
Tantrums				
Shyness with strangers				
Clingy				
Self-injurious behavior (cutting on own skin, burning self on purpose, etc)				
Suicidal statements				
Serious threats to harm others				
Physical aggression towards others				
Cruelty towards animals				

Sensory Issues	**Yes**	**No**	**Unknown**	**If yes, still occurring?**
Poor muscle tone and/or coordination				
Hypersensitive (overly sensitive) to touch				
Hyposensitive (under sensitive) to touch				
Hypersensitive (overly sensitive) to sounds				
Hyposensitive (under sensitive) to sounds				
Hypersensitive (overly sensitive) to visual input				
Hyposensitive (under sensitive) to visual input				
Hypersensitive to (overly sensitive) smells				
Hyposensitive (under sensitive) to smells				
Education/School Functioning	**Yes**	**No**	**Unknown**	**If yes, still occurring?**
Performing below expectations at school				
Learning problems				
Repeated a grade (or is scheduled to repeat a grade)				
Evaluated for special education services, but did not qualify for services				
Receives special education services or has a 504 plan				
Has an identified learning disability				
Multiple detentions or suspensions				
Truancy (with or without court action)				
Receives special education services for behavior or emotional problems				
Enrollment in an alternative learning center (ALC) or is home-schooled				
Trauma History (Has the child experienced any of the following)	**Yes**	**No**	**Unknown**	**If yes, still occurring?**
Physical abuse				
Domestic violence/abuse				
Physical neglect				
Emotional abuse				
Sexual abuse/molestation				
Community violence				
Children's Protective Services involvement with the family				
Other traumatic experiences or losses				

Substance Use

Do you have any concerns about this child's use of alcohol or drugs? ___ Yes ____No

Substance	Past Use	Current Use
Alcohol		
Tobacco		
Caffeine		
Marijuana		
Methamphetamine		
Narcotics		
Cocaine		
Heroin		
Prescription Drugs		
Other:		

To be completed by adolescents (ages 12-17)

Have you used more than one **chemical** at a time in order to get high? ____Yes _____ No

Do you **avoid** family activities so you can use? ____Yes _____ No

Do you have a **group** of friends who also use? ____Yes _____ No

Do you use to improve your **emotions,** such as when you feel sad or depressed? ____Yes _____ No

Legal issues as a result of use: _____ No ___ Yes Describe: _____

_____

Does this child have a history of participating in a chemical dependency treatment program? ____ No _____ Yes

If yes, please describe when and where they were in treatment:_____

_____

Legal History

Does this child have a history of legal charges? _____No _____Yes

If yes, please describe charges:_____

_____

Is the child currently on probation? _____No _____Yes Has the child ever been on probation? ____No ____Yes

Are the following symptoms present?

Oppositional and Defiant Behaviors	**Never/Rarely**	**Sometimes**	**Often**	**Very Often**
Loses temper				
Argues with adults				
Actively defies or refuses to comply with adults' requests or rules				
Deliberately annoys people				
Blames others for his or her mistakes or misbehavior				
Is touchy or easily annoyed by others				
Is angry or resentful				
Is spiteful or vindictive, holds a grudge				
Impulsive, Hyperactive and Inattentive Behaviors	**Never/Rarely**	**Sometimes**	**Often**	**Very Often**
Fails to give close attention to details, makes careless mistake in schoolwork				
Has difficulty sustaining attention in tasks or play activities				
Does not seem to listen when spoken to directly				
Does not follow through on instructions and fails to finish work/chores				
Has difficulty organizing tasks and activities				
Avoids or dislikes to engage in tasks that require sustained mental effort (such as school work, homework)				
Loses things necessary for tasks and activities (toys, assignments, pencils, etc)				
Is easily distracted by extraneous stimuli				
Is forgetful in daily activities				
Fidgets with hands or feet or squirm in seat				
Leaves seat in classroom, other situations				
Runs about or climbs excessively in situations where it is inappropriate				
Has difficulty playing quietly/leisure quietly				
Is "on the go" or acts if "driven by a motor"				
Talks excessively				
Blurts out answers before questions have been completed				
Has difficulty awaiting turn				
Interrupts or intrudes on others				

Mood Regulation	Never/Rarely	Sometimes	Often	Very Often
Rapid and extreme mood swings				
Explosive rages				
Periods of exaggerated sense of self-importance or achievement				
Periods of having racing thoughts or fast speech				
Periods of very elated mood, feeling excessively joyful				
Periods of decreased need for sleep				
Increase in goal-directed activity				
Depressed mood				
Irritability				
Withdrawal				
Indecisiveness				
Crying spells				
Excessive worry about many things				
Specific fears				
Nightmares				
Exaggerated startle response				

Anxiety Related Symptoms	Yes	No
Does your child have a distinct and ongoing fear of social situations involving unfamiliar people?		
Does your child worry excessively about a number of events or activities?		
Does your child experience shortness of breath or a racing heart for no apparent reason?		
Does your child often appear anxious when interacting with peers, or try to avoid them?		
Does your child have a persistent and unreasonable fear of an object or situation, such as flying, heights, or animals?		
When encountering the feared object or situation, does he/she react by freezing, clinging, or having a tantrum?		
Does your child worry excessively about her competence and quality of performance?		
Does your child cry, have tantrums, or refuse to leave a family member or other familiar person when necessary?		
Has your child experienced a decline in classroom performance, refused to go to school, or avoided age-appropriate social activities?		
Does your child spend at least one hour each day repeating things over again, such as hand washing, checking, arranging, or counting?		
Does your child have exaggerated and irrational fears of people, places, objects or situation's that interfere with his or her social and academic life?		
Does your child experience a great number of nightmares, headaches, or stomachaches?		
Does your child repetitively use toys to re-enact scenes from a disturbing event?		
Does your child redo tasks because of excessive dissatisfaction with less-than-perfect performance?		

Please identify some of this child's strengths and interests: _____

_____

_____

_____

Please provide any additional information you would like to share: _____

_____

_____

_____

To be completed by adolescents (ages 12-18)

Patient Health Questionnaire (PHQ-9--Modified for Teens)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Feeling down, depressed, irritable or hopeless				
Little interest or pleasure in doing things				
Trouble falling or staying asleep or sleeping too much				
Poor appetite, weight loss, or overeating				
Feeling tired or having little energy				
Feeling bad about yourself --or feeling that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, like school work, reading or watching TV				
Moving or speaking so slowly that other people could have noticed - Or the opposite – being so fidgety or restless that you were moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				

In the ***past year*** have you felt depressed or sad most days, even if you felt OK sometimes? □ Yes □ No

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**

Has there been a time in the past month when you have had serious thoughts about ending your life? □ Yes □ No
Have you ***ever***, in your ***whole life***, tried to kill yourself or made a suicide attempt? □ Yes □ No