Holland Hospital

Child and Adolescent Confidential Questionnaire

Behavior Health Services

Please take a few minutes to complete this questionnaire. This information will be helpful to us as we learn about your personal concerns. It is very important that you provide accurate information. This questionnaire will become part of your confidential medical record.

Today's Date: ____/____/____ Person Completing Form: _____

PATIENT INFORMATION

Name: _____ Birthday: ___/___/___ _____ Yrs.
Last First

Previous Name: _____ Sex: ❒ M ❒ F

Mailing Address _____
Street/Avenue Apt.#

_____
City State Zip

Current Residence _____
Street/Avenue Apt.#

_____
City State Zip

Home Phone #: _____ Daytime Phone #: _____

Cell #: _____ Preferred Method of Contact: _____

Employment: ❒ Full Time ❒ Part Time ❒ Self-Employed ❒ Student
❒ Other: _____

Child's Physician: _____

Employer: _____ Employer Phone #: _____

PARENTS

Mother: _____ DOB: ____/____/____
Last First

_____ _____
Street/Avenue City State Zip

Father: _____ DOB: ____/____/____
Last First

_____ _____
Street/Avenue City State Zip

Stepparent: _____ DOB: ____/____/____
Last First

_____ _____
Street/Avenue City State Zip

Stepparent: _____ DOB: ____/____/____
Last First

_____ _____
Street/Avenue City State Zip

If separated or divorced, custody arrangement: Mother: ❒ Joint ❒ Physical
Father: ❒ Joint ❒ Physical

INSURANCE INFORMATION

Primary Insurance: _____ Policy Holder: _____
Group #: _____ DOB of Policy Holder: ____/____/____
Employer: _____ Contract #: _____

Secondary Insurance: _____ Policy Holder: _____
Group #: _____ DOB of Policy Owner: ____/____/____
Employer: _____ Contract #: _____

Holland Hospital

CHILD AND ADOLESCENT CONFIDENTIAL QUESTIONNAIRE

BEHAVIORAL HEALTH SERVICES

Initial Assessment (Part I)

Child / Adolescent's Name: _____ Birthday: ___/___/___ Age: ____
Last First

Person completing report: _____ Relationship: _____

What symptoms or problems bring you to this appointment? _____

_____

_____

_____

_____

FAMILY INFORMATION

Is your child: ❒ Adopted ❒ Foster ❒ Natural Are parents living together? ❒ Yes ❒ No
Are parents divorced? ❒ Yes ❒ No Does your child have stepparents? ❒ Yes ❒ No

Names of Sisters/Brothers:	Age	Quality of Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is there any family history of mental health or psychiatric problems, alcoholism, or other substance abuse problems? ❒ Yes ❒ No If yes, please list below:

How is that Family member Related to the child?	Type of Problem	Treatment/Medications	Helpful?
_____	_____	_____	❒ Yes ❒ No
_____	_____	_____	❒ Yes ❒ No
_____	_____	_____	❒ Yes ❒ No
_____	_____	_____	❒ Yes ❒ No
_____	_____	_____	❒ Yes ❒ No

Is there any history of suicide in your family? ❒ No ❒ Yes If so, what relation to you?
_____

Describe your child's relationship with other adults: ❒ Good ❒ Fair ❒ Poor
Describe your child's relationship with other children: ❒ Good ❒ Fair ❒ Poor
Level of stress in the family: ❒ Extremely Stressed ❒ Moderately ❒ Somewhat ❒ Not at all
Have there been any major family stresses or changes in the past year? (e.g. – moving, divorce, significant illness)
❒ Yes ❒ No If yes, explain_____

_____

Level of stress in the marriage: ❒ Extremely Stressed ❒ Moderately ❒ Somewhat ❒ Not at all
How is the child disciplined: ❒ Privileges Removed ❒ Grounded ❒ Time-Out ❒ Other:_____

_____

What do you like most about this child? _____

_____

What concerns you most about this child?_____

Pt. Name: _____

DEVELOPMENTAL HISTORY

During the pregnancy with this child, were there any troubles, complications, or concerns? ❒ Yes ❒ No
If yes, explain_____
Were there any problems during the birth? ❒ Yes ❒ No If yes, explain_____
_____
Did your child start walking by: ❒ 12 Mos. ❒ 14 Mos. ❒ 18 Mos.
Did your child say their first word by: ❒ 12 Mos. ❒ 14 Mos. ❒ 18 Mos.
Did your child begin talking in 2-3 word sentences by: ❒ 24 Mos. ❒ 28 Mos. ❒ 36 Mos.
Did your child become toilet trained by: ❒ 24 Mos. ❒ 36 Mos. ❒ 48 Mos.
Does your child have a history of abuse or trauma? ❒ Yes ❒ No
If yes; type of abuse: ❒ Sexual ❒ Physical ❒ Emotional
Abuse was as: ❒ Victim ❒ Perpetrator: Explain: _____

EDUCATIONAL HISTORY

The child's present school is: Name_____
Address_____
Phone # (_____)_____ Contact Person_____
(teacher, counselor, etc.)
Was the child ever held back to repeat a grade? ❒ Yes ❒ No
If yes, which grade?_____ Why?_____
Has the child ever been in a special class or provided with special services? ❒ Yes ❒ No
(e.g. – resource room, EMR, learning disability class, gifted class) If yes, describe the special class:
_____
Is the child in this class or receiving special services now? ❒ Yes ❒ No
Does the child like school? ❒ Most of the time ❒ Sometimes ❒ Never
Does the child: Have problems with other children in class? ❒ Yes ❒ No
Have problems making friends in school? ❒ Yes ❒ No
Have problems getting along with teachers? ❒ Yes ❒ No
Tend to get sick in the morning before school? ❒ Yes ❒ No
What kind of grades has the child received in the past year? (If given grades at school)
❒ A's & B's ❒ B's & C's ❒ C's & D's ❒ D's and F's
OR-
❒ Outstanding ❒ Good ❒ Satisfactory ❒ Improvement Needed
Are these grades a change from previous years? ❒ Yes ❒ No
In the past year, how much school has the child missed due to illness or injury?
❒ Less than 2 weeks ❒ 2 to 4 weeks ❒ 5 to 8 weeks
Are child's absences other than illness related? ❒ Yes ❒ No If yes, explain_____
_____
Does the child seem to have a "school phobia?" ❒ Yes ❒ No If yes, explain_____
_____
What are your child's academic strengths?_____
What are your child's academic weaknesses?_____
Has there been a previous diagnosis of learning disabilities? ❒ Yes ❒ No
If so, by whom and when?_____
Has either parent been diagnosed with a learning disability or problems in school as a child?
❒ Yes ❒ No If yes, explain_____
Has there been a previous diagnosis of Attention Deficit/Hyperactivity Disorder?
❒ Yes ❒ No If so, by whom and when?_____

Pt. Name: _____

TREATMENT HISTORY

Has your child had outpatient counseling or therapy before? ❒ Yes ❒ No

When and with whom? _____

_____

Was it helpful? ❒ Yes ❒ No, explain?_____

_____

Has your child ever been treated with psychiatric medication(s) before? ❒ Yes ❒ No

When and by whom? _____

_____

What medications? _____

_____

Did she/he experience any side effects?_____

Has your child ever been hospitalized for a psychiatric condition? ❒ Yes ❒ No

If yes, give admission(s) date, hospital, and reason for admission: _____

_____

_____

_____

Has your child ever made a suicide attempt? ❒ Yes ❒ No Explain: _____

_____

_____

Did he/she receive treatment for this? _____

_____

CURRENT SUBSTANCE USE / ABUSE HISTORY:

___ Alcohol
___ Cannabis / Marijuana
___ Cocaine / Crack
___ Caffeine, daily amount _____
___ Stimulants (speed, minithins, etc.)
___ Sedative/Hypnotic (barbiturates, BZ's, etc.)
___ Opiates (opium, heroin, narcotic pain meds)
___ Hallucinogens
___ Inhalants (rush, poppers, solvents, glues)
___ Cigarettes/Nicotine, daily amt. _____ How Long? _____

Complete the following information for each numbered item:

	Specific Substance	Last Use Date/Time	Frequency	Dose/Amount
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Adverse consequences of usage: ❒ Social _____ ❒ Legal _____
❒ Occupational _____ ❒ Other _____

History of emotional/psychiatric issues prior to onset of substance abuse: ❒ No ❒ Yes, explain: _____

_____

_____

_____

_____

_____

Pt. Name: _____

CULTURAL/ETHNIC

Does your child have any cultural or ethnic issues you would like us to be aware of: ❒ No ❒ Yes
Explain: _____
_____

SPIRITUAL/RELIGIOUS

Does your child have a supportive faith community? ❒ No ❒ Yes

How important have spiritual matters been in the family? ❒ Minimal ❒ Moderate ❒ High
Spiritual needs? ❒ No ❒ Yes, explain: _____
_____

LEISURE/RECREATIONAL

Special areas of interest:

Activity	Recent Changes:
_____	❒ Yes ❒ No, explain: _____
_____	❒ Yes ❒ No, explain: _____
_____	❒ Yes ❒ No, explain: _____

LEGAL

Child's present legal involvement: ❒ None ❒ On probation
Probation officer: ❒ No ❒ Yes Name _____
Does your child have any pending legal charges? ❒ No ❒ Yes Explain: _____
_____
Does your child have past legal charges? ❒ No ❒ Yes Explain: _____
_____

SOCIAL RELATIONSHIPS

Usual response to social relationships:

❒ Avoidant	❒ Shy/Withdrawn	❒ Follower	❒ Friendly
❒ Leader	❒ Argumentative	❒ Aggressive	❒ Outgoing

Are you satisfied with your child's current social relationships: ❒ Yes ❒ No, explain: _____
_____
Recent changes in child's social relationships: ❒ Yes ❒ No, explain: _____
_____

FINANCIAL/ENVIRONMENTAL

Finances:	❒ Adequate	❒ Inadequate	Shelter:	❒ Adequate	❒ Inadequate
Food:	❒ Adequate	❒ Inadequate	Transportation:	❒ Adequate	❒ Inadequate
Clothing:	❒ Adequate	❒ Inadequate			

Additional Comments (If needed):
Is there anything else about your child that may be important for us to know so we may be of help to them?

_____
_____
_____
_____
_____
_____
_____
_____

Pt. Name: _____

HISTORY OF PROBLEMS

We would like you to tell us about your child's current problem. Please circle the number which best describes your child.

	NOT A PROBLEM	LESS THAN 6 MONTHS	6 MOS. TO 1 YR.	1-2 YRS.	MORE THAN 2 YRS.	PRIOR PROBLEM RESOLVED
PROBLEMS WITH SLEEP						
Trouble sleeping	1	2	3	4	5	6
Nightmares	1	2	3	4	5	6
Sleep walking	1	2	3	4	5	6
Sleep talking	1	2	3	4	5	6
SCHOOL PROBLEMS						
Has problems learning in school	1	2	3	4	5	6
Is afraid to go to school	1	2	3	4	5	6
Won't obey school rules	1	2	3	4	5	6
Often skips school	1	2	3	4	5	6
Has conflicts with teachers	1	2	3	4	5	6
Performs below his/her ability	1	2	3	4	5	6
RELATIONSHIP WITH OTHER CHILDREN						
Picks on other children	1	2	3	4	5	6
Has few or no friends	1	2	3	4	5	6
Is called weird by other children	1	2	3	4	5	6
Plays alone most of the time	1	2	3	4	5	6
Fights with other children	1	2	3	4	5	6
Has sex play with other children	1	2	3	4	5	6
Hangs around with bad crowd	1	2	3	4	5	6
Tries to boss others around	1	2	3	4	5	6
BEHAVIORAL PROBLEMS						
Uses drugs	1	2	3	4	5	6
Runs away from home	1	2	3	4	5	6
Uses alcohol	1	2	3	4	5	6
Lies	1	2	3	4	5	6
Steals	1	2	3	4	5	6
Sets fires	1	2	3	4	5	6
Breaks things	1	2	3	4	5	6
Hurts animals	1	2	3	4	5	6
Assaultive	1	2	3	4	5	6
SOCIAL SKILLS						
Afraid of many things	1	2	3	4	5	6
Very shy	1	2	3	4	5	6
Poor loser	1	2	3	4	5	6
Demands too much attention	1	2	3	4	5	6
Withdraws from people	1	2	3	4	5	6

Pt. Name: _____

HISTORY OF PROBLEMS? (continued)

	NOT A PROBLEM	LESS THAN 6 MONTHS	6 MOS. TO 1 YR.	1-2 YRS.	MORE THAN 2 YRS.	PRIOR PROBLEM RESOLVED
OTHER PROBLEMS WITH RELATIONSHIPS						
Talks back to adults	1	2	3	4	5	6
Disobeys parents	1	2	3	4	5	6
Can't be trusted	1	2	3	4	5	6
Isolates him/herself in room	1	2	3	4	5	6
Has a "chip" on his/her shoulders	1	2	3	4	5	6
Doesn't trust other people	1	2	3	4	5	6
EMOTIONAL PROBLEMS						
Is sad or unhappy most times	1	2	3	4	5	6
Cries a lot	1	2	3	4	5	6
Has temper tantrums	1	2	3	4	5	6
Mood changes quickly	1	2	3	4	5	6
Has lost interest in things	1	2	3	4	5	6
Worries a great deal	1	2	3	4	5	6
Has difficulty making decisions	1	2	3	4	5	6
Has difficulty concentrating	1	2	3	4	5	6
OTHER						
Has threatened or attempted to harm self	1	2	3	4	5	6
Acts younger than real age	1	2	3	4	5	6
Wants things to be perfect	1	2	3	4	5	6
Can't sit still	1	2	3	4	5	6
Acts without thinking	1	2	3	4	5	6
Says or does strange things	1	2	3	4	5	6
Daydreams a lot	1	2	3	4	5	6
Doesn't finish things	1	2	3	4	5	6
Stutters	1	2	3	4	5	6
Is easily distracted	1	2	3	4	5	6
Bites nails	1	2	3	4	5	6
Doesn't speak well	1	2	3	4	5	6
Not fully bladder trained	1	2	3	4	5	6
Not fully bowel trained	1	2	3	4	5	6
Tired most of the time	1	2	3	4	5	6
Has aches and pains	1	2	3	4	5	6
Clumsy and accident prone	1	2	3	4	5	6
Fakes being sick	1	2	3	4	5	6
Chronically ill	1	2	3	4	5	6

Pt. Name:_____

MEDICAL SUMMARY LIST

Does your child have any current medical conditions? ❒ No ❒ Yes (If yes, please list below)

_____

Child's last contact with Primary Care Physician: ____/____/____ Last physical: ____/____/____

Are your immunizations up to date? ❒ Yes ❒ No

CURRENT MEDICATIONS (Include non-prescription meds, vitamins, and herbal)

	Dose	Taken how often?	Reason	Who Prescribed?
1.				
2.				
3.				
4.				

Is your child allergic to any medications? ❒ No ❒ Yes Which ones? _____

What kind of reactions did he/she have? _____

HEALTH FACTORS - Does your child have any history of . . .

	No	Yes		No	Yes
Cancer			Blood Sugar Problems		
Heart Problems			Thyroid Disease		
Seizures			Eye Diseases		
Head Injuries			Prostrate Problems		
Kidney Problems			PMS		
Liver Problems			Other		

Describe: _____

_____

NUTRITION

Does your child have a history of having unintentional weight gain or loss? ❒ Yes ❒ No

CHRONIC PAIN

Does your child have a history of chronic pain? ❒ No ❒ Yes

Rate current level of pain – "1–10" (1 being lowest, 10 being highest): _____

Location/Current Treatment: _____

_____

SURGICAL: (List surgeries and dates)

_____

SEXUAL

Does your child use birth control? ❒ Yes ❒ No ❒ N/A What kind? _____

Has your child ever had a sexually transmitted disease? ❒ No ❒ Yes ❒ N/A

If yes, please explain:

_____

FEMALES ONLY

Are your daughter's periods regular? ❒ Yes ❒ No ❒ N/A Date of last period: _____

Does your daughter experience severe mood swings around her period? ❒ Yes ❒ No ❒ N/A

Is there any possibility she may be pregnant? ❒ Yes ❒ No ❒ N/A

THANK YOU FOR YOUR HELP IN PROVIDING THIS INFORMATION!