Authentic Self Psychotherapeutic Services
1920 Palm Beach Lakes Blvd., Suite 206 West Palm Beach, Florida 33401 561-207-7702

Child-Adolescent Questionnaire

IDENTIFYING INFORMATION

Date: ____________

Name: ____________________________________ SS#: ______________________

Gender: ______________ DOB: ____________ Age: _________

Race/Ethnicity: ___________Country of Birth: __________Marital status: ______________

Highest Education Completed: _________________ Occupation: _________________

Address: ____ Phone Number: ________
Street City, State Zip

Referral Source: _____________________________ Phone Number: ______________

Reason for referral: ____

CHIEF COMPLAINT

Please describe the major problem for which you are seeking help:

Presenting problem(s)	Onset
1.	
2.	
3.	

Additional information: ____
____

PROBLEM CHECKLIST:

Please check all that apply (recently):

- o Difficulty Concentrating
- o Seeing things that aren't there
- o Hearing things
- o Trouble w/ memory
- o Distrustful
- o Unreasonable fears
- o Panic attacks
- o Feelings of sadness
- o Hopelessness
- o Feel useless
- o Feel lonely
- o Law breaking
- o School problems
- o Anxious/Tense
- o Headaches
- o Problems sleeping
- o Anger
- o Loss of appetite
- o Eating disorder
- o Drugs/alcohol
- o Relationship problems

PERSONAL / FAMILY/ SOCIAL

Father's Name: ____________________ _____ Occupation: ___________________ Age: ____

Mother's Name: _________________________ Occupation: __________________ Age: ____

Parent's Marital Status: Married Divorced Separated Never Married

Siblings (Names/ages):____

Family history of psychiatric illness: yes/no
If yes, please describe: ____

Current living arrangements? ____

MEDICAL/PSYCHIATRIC TREATMENT

Have you ever received treatment from a therapist, psychologist, or psychiatrist in the past? If so, please describe:

Date	Length of time	Chief complaint?	Services Provided	Diagnosis (if any)

Have you recently had changes with:

Symptom	Response	Descriptor	Additional Information
Weight Loss / Gain	Yes _____ No _____	Number of pounds	
Appetite	Yes _____ No _____	Increase / Decrease	
Sleep disturbances	Yes _____ No _____	Insomnia / Hypersomnia	
Loss of interest in normal activities	Yes _____ No _____		

Do you know what suicide is? Yes ______ No ______

Have you ever attempted suicide or intentionally hurting yourself? Yes _______ No ______

If yes, please explain: ____

Have you ever had so much energy you did not know what to do with yourself? Yes ___ No ___

If yes, please explain: ____

Have you ever been a victim of physical abuse? Yes_____ No _____ Explain: ___________

Have you ever been a victim of sexual abuse? Yes _____ No ______ Explain: ____________

____

Do you have current or past medical conditions/illnesses/hospitalizations? If so, please describe:

Date	Length of treatment	Illness/ Reason for hospitalization	Outcome

Name of Pediatrician: ___________________________________ Telephone #: ______________________

Are you currently taking any medications (for physical or mental health conditions):

Name of medication	Dosage	Frequency

Are medications being taken as prescribed? Yes ______ No ______

When are these medications taken (time of day) ___________________________________

SUBSTANCE USE

Substance	Age of first use	Frequency of use	Route of administration	Date of last use
Tobacco				
Caffeine				
Marijuana				
Cocaine				
Opiates				
Heroine				
Benzodiazepines				
Amphetamines				
Methamphetamines				
Other: ______________				

LEGAL INVOLVEMENT

Have you ever been involved with the police or court system? Yes ______ No ______

If yes, please describe: ____

____

Do you have any charges pending? Yes ______ No ______

MENTAL STATUS

(To be completed by clinician)

Appearance	Appropriate	Disheveled	Bizarre	Nervous	Guarded	Tremulous
Mood	Euthymic	Anxious	Depressed	Angry	Euphoric	Irritable
Affect	Full	Constricted	Blunted	Flat	Labile	Approp. to mood
Thought Process	Normal	Logical	Disorganized	Tangential	Circumstantial	Flight of Ideas
Memory	Oriented X4	Disoriented	Recent: Normal ___ Impaired _____		Remote: Normal ___ Impaired ___	