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CHILDREN / ADOLESCENT SERVICE QUESTIONNAIRE

I. Reason for Referral

Child's name: _____ Age:_____
Your name: _____
Relation to child: _____
Who referred you? _____
Please give a brief description of the problems you are having with your child and how you would like for us to help.

_____
_____
_____
_____
_____

II. Family Make-up

Biological Mother: _____
Biological Father: _____
Step-Mother: _____
Step-Father: _____
Sibling: _____ Age _____
Sibling: _____ Age _____
Sibling: _____ Age _____
Sibling: _____ Age _____

(Please put check mark(s) beside parent(s) with primary custody)

III. History of the Problem

How long has this been a problem, and what have you tried to do about it in the past?

_____
_____
_____
_____

IV. School Functioning

Are there any major problems at school in terms of grades, peer relations, relations with teachers, etc?

_____
_____
_____
_____

V. Past Mental Health History

What prior treatment has your child had, with whom, and how useful was it?

_____
_____
_____

VI. General Medical History

What medical problems, if any, has your child had during pregnancy, delivery, and subsequently? Any history of head injuries or seizures? Any serious headaches or stomachaches?

_____
_____
_____
_____

VII. What medications is your child on, who prescribed them, and for what purpose?

Medication	Doctor	Purpose