LifeStance HEALTH

Child Questionnaire

PRESENTING PROBLEM – Please briefly describe your concern(s)

CURRENT MEDICATIONS	PAST PSYCHIATRIC MEDS	ALLERGIES

MENTAL HEALTH HISTORY

Has the child had past or current outpatient mental health treatment? ☐ Yes ☐ No
If yes, please specify, include provider and dates of treatment below:

Type	Provider/Date
☐ Individual Therapy	
☐ Family Therapy	
☐ Med Management	
☐ Psychological Testing	
☐ Psychiatric Hospital Admission	

Additional Behavioral Health Information History

Please provider additional information regarding hospitalizations and medications:

Current Living Situation:

Who is living in the home and their relationship to the child:

Cultural/Ethnic/Spiritual Considerations/Identities:

☐ Unknown Family History/Adopted

Does the child or a family member have a history or prior diagnosis of:

	Child	Family Members:
ADD/ADHD	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Autism Spectrum Disorder	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather

Bipolar Disorder	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Depression	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
DMDD	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Eating Disorder	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Encopresis/Enuresis	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Learning Disorder	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Mania	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Obsessive-Compulsive Disorder	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Oppositional Defiant Disorder	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Panic Attacks	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
PTSD/Trauma	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Schizophrenia	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Separation Anxiety	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Social Anxiety	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Substance Use/Dependence	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Tourette's	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Other:	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather

MEDICAL HISTORY	
Pediatrician: ☐ Yes ☐ No	**Name/Phone #:**
Date of Last Physician Exam:	
Date of Last Dental Exam:	
Date of Last Vision Exam:	
Additional Healthcare Providers: ☐ Yes ☐ No	If yes, include name and phone numbers:

Has the child received immunizations? ☐ Yes ☐ No
Are the child's immunizations up to date? ☐ Yes ☐ No

Does the child have an eating or sleeping problem? Select all that apply.		
	Child	**Family Members:**
Asthma	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Anemia	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Cancer/Leukemia	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Cerebral Palsy	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Diabetes	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Down's Syndrome	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Ear Infections	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Encephalitis	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Epilepsy/Seizures	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Fever above 105 degrees	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Hearing Problems	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Heart Problems/Disease	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
HIV/AIDS	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Hydrocephalus	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Lead Poisoning	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Liver Disease	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Loss of Consciousness/Head Injury	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Meningitis	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Musculoskeletal Condition	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Strep Infection	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather

Stroke	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Thyroid Problems	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Visions Problems:	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Other:	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather

Does the child have an eating or sleeping problem? Select all that apply.

☐ Dieting ☐ Overeating ☐ Picky eater ☐ Recent weight gain ☐ Recent weight loss ☐ Refuses to eat ☐ Vomiting ☐ Other:	☐ Bedwetting ☐ Difficulty falling asleep ☐ Does not want to sleep alone ☐ Nightmares ☐ Sleeps to much ☐ Soiling ☐ Trouble staying asleep ☐ Very restless at night

How would you describe the nutritional value and balance of the child's diet? ☐ Good ☐ Fair ☐ Poor

Examples of Typical Diet:
Breakfast:
Lunch:
Dinner:

Does the child have an eating or sleeping problem? Select all that apply.

Cognitive Issues:	Sensory Issues:
☐ Lack of varied, spontaneous make-believe play ☐ Restricted patterns of behavior, activities or interests ☐ Repetitive patterns of behavior, interest or activities ☐ Preoccupation with parts of an object ☐ Cognitive disabilities ☐ Intense/all-encompassing interests	☐ Overly sensitive to sounds ☐ Other sensory issues ☐ Coordination problems

DEVELOPMENTAL HISTORY

Prenatal/Birth:

Health of the mother during pregnancy: ☐ Good ☐ Fair ☐ Poor ☐ Unknown
Did the mother use any of the following during pregnancy? ☐ Yes ☐ No ☐ Unknown
☐ Alcohol ☐ Cigarettes ☐ Marijuana ☐ Cocaine/Crack ☐ Coffee/Caffeine Drinks
☐ Prescription Drugs (please list):

Any medical complications during pregnancy? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Length of Pregnancy: ☐ Full-term ☐ Late preterm (32-36 weeks) ☐ Very preterm (28-31 weeks)
☐ Extremely preterm (Less than 28 weeks) ☐ Unknown

Birth Weight:

Were there any complications during or following birth (select all that apply)?
☐ Baby given oxygen ☐ Baby on heart monitor ☐ Birth defects ☐ Blood transfusions (baby)
☐ Delivery aided by instrument ☐ Delivery by cesarean section ☐ Incubator ☐ Jaundice ☐ Rashes
☐ Problems breathing ☐ Problems eating/digestion ☐ Problems sucking ☐ Very active ☐ Very quiet
☐ Other:

Early Development:

At what age did the child begin:
Walking (months): _____ Toilet training daytime: _____
Talking (single words): _____ Toilet training nighttime: _____
Talking (short sentences 2+ words): _____

Child can throw a ball: ☐ Yes ☐ No
Child can catch a ball: ☐ Yes ☐ No
Child had no trouble learning to hold a pencil: ☐ Yes ☐ No
Child easily learned to zip zippers, ties shoes and button clothes: ☐ Yes ☐ No

During the first 3 years of life, the child frequently exhibited (select all that apply):
☐ Accident-prone behavior ☐ Avoidance of cuddling ☐ Colic ☐ Distractibility ☐ Extreme mood changes
☐ Problems with sleeping/walking patterns ☐ Feeding problems ☐ Lack of coordination
☐ Overactive behavior ☐ Restless behavior ☐ Self-hurting behavior ☐ Temper tantrums
☐ Head banging ☐ Unresponsive to discipline

Activities of Daily Living:

Assigned chores or responsibilities: ☐ Yes ☐ No
Chores or responsibilities being done: ☐ Yes ☐ No
Needs prompting: ☐ Yes ☐ No
Please describe:

Performing self-care appropriate for age level: ☐ Yes ☐ No
Needs prompting: ☐ Yes ☐ No
Please describe:

SUBSTANCE/ALCOHOL USE HISTORY

Alcohol Use:

Does the child drink alcohol? ☐ Yes ☐ No

Additional Information/Concerns:

Smoking History:

Smoking Status: ☐ Nonsmoker ☐ Ex-smoker ☐ Cigar smoker ☐ Chew tobacco ☐ Current everyday smoker
☐ Current heavy tobacco smoker ☐ Current light tobacco smoker ☐ Pipe smoker ☐ Snuff user
Usage per Day: _____ Number of Years: _____
Do you vape? ☐ Yes ☐ No
Others Smoking in the Home: ☐ Yes ☐ No

Educational History:

Highest grade level completed: _____
Current grade: _____
Name of school presently attending: _____
Number of schools previously attending: _____

School-related issues (select all that apply):
☐ 504 Plan ☐ Advanced a grade ☐ Academic problems ☐ Attendance ☐ Behavior ☐ Bullying
☐ Detention ☐ Expulsion ☐ IEP ☐ Held back a grade ☐ Homework ☐ Learning disabilities
☐ Met with school counselor ☐ Occupational therapy ☐ Peer relationships ☐ Physical therapy
☐ Relationship with teacher(s) ☐ Required special help ☐ School modifications ☐ Speech therapy
☐ Suspension (in school) ☐ Suspension (out of school) ☐ Tested by school psychologist (ADD, ADHD, other)
☐ Transportation

Please describe and include any additional educational stressors:

Additional School History:

How easy is it for the child to make friends? ☐ More difficult ☐ Average ☐ Easier than average

How does the child get along with siblings? ☐ More difficult ☐ Average ☐ Easier than average

What are the child's strengths?	Please describe extracurricular activities, employment and other pertinent information.

Thank you for taking the time to complete this questionnaire.

Completed by: _____ Date Completed: _____

Relationship to Patient: ☐ Self ☐ Patient ☐ Guardian ☐ Other: _____