Nexus-FACTS FAMILY HEALING

Family, Adolescents, and Children Therapy Services

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History Questionnaire - Child or Adolescent

Please take time to fill out this form for your child.
This will aid greatly in providing appropriate therapeutic care for them.

Name of Child: _____ DOB: _____

BIRTH HISTORY

Pregnancy

Which of the mother's pregnancies was this? (1st, 2nd, etc.) _____

☐ Yes ☐ No Has the mother had any miscarriages

☐ Yes ☐ No Any previous premature babies?

Length of pregnancy in weeks (most babies are born 38-42 weeks) _____

☐ Yes ☐ No Illness/Infection/Accident during pregnancy? Describe: _____

☐ Yes ☐ No Medication during pregnancy Describe: _____

☐ Yes ☐ No Was this a planned pregnancy? Describe: _____

☐ Yes ☐ No Depression/Stress during pregnancy? Describe: _____

☐ Yes ☐ No Alcohol use during pregnancy? Describe: _____

☐ Yes ☐ No Smoke cigarettes during pregnancy? Describe: _____

☐ Yes ☐ No Drug use during pregnancy? Describe: _____

Labor and Delivery

☐ Yes ☐ No Induced?

☐ Yes ☐ No Labor lasted more than 12 hours?

☐ Yes ☐ No C-Section? If yes, reason: _____

☐ Yes ☐ No Anesthesia? If yes, type: ☐ Spinal ☐ Epidural ☐ General (Asleep)

☐ Yes ☐ No Any complications with labor or delivery?

Describe if yes: _____

_____

Birth Weight _____ lbs _____ oz

☐ Yes ☐ No Breastfed?

How many days spent in the hospital? _____

Infancy

☐ Yes ☐ No Enjoyed cuddling?

☐ Yes ☐ No More active than other babies?

☐ Yes ☐ No Colic?

☐ Yes ☐ No Fussy, Irritable

☐ Yes ☐ No Sleeping difficulties

☐ Yes ☐ No Eating difficulties

Briefly describe your child as a toddler: _____

DEVELOPMENTAL HISTORY

As best you can recall, record the age at which your child reached the following developmental milestones. If you cannot recall, check the appropriate box.

Milestone:	Age:	Best recollection if exact age is not recalled:		
Sat without support	_____	☐ Early	☐ Normal	☐ Late
Crawled	_____	☐ Early	☐ Normal	☐ Late
Stood without support	_____	☐ Early	☐ Normal	☐ Late
Walked without assistance	_____	☐ Early	☐ Normal	☐ Late
Threw Ball	_____	☐ Early	☐ Normal	☐ Late
Spoke first words	_____	☐ Early	☐ Normal	☐ Late

(continued) Milestone:	Age:	Best recollection if exact age is not recalled:

Spoke phrases	_____	☐ Early	☐ Normal	☐ Late
Spoke sentences	_____	☐ Early	☐ Normal	☐ Late
Bowel trained	_____	☐ Early	☐ Normal	☐ Late
Bladder trained, day	_____	☐ Early	☐ Normal	☐ Late
Bladder trained, night	_____	☐ Early	☐ Normal	☐ Late
Tied shoelaces	_____	☐ Early	☐ Normal	☐ Late

List any childhood illnesses, serious accidents, or hospitalizations:

Age at time of incident: Describe incident:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

☐ Yes ☐ No History of head injury or loss of consciousness Describe: _____

☐ Yes ☐ No History of seizures Describe: _____

☐ Yes ☐ No Allergies Describe: _____

☐ Yes ☐ No Current health problems Describe: _____

☐ Yes ☐ No Current infectious disease(s) Describe: _____

☐ Yes ☐ No Current medications Describe: _____

Name of medications: _____

Dose/frequency: _____

Additional comments: _____

_____

_____

Describe your child in the following areas:

Sleeping habits: _____

_____

Eating habits: _____

_____

Energy level: _____

_____

☐ Yes ☐ No Does your child or anyone living with you have an infectious disease?

If yes, what? _____

Current height of your child: ft inches Current weight of your child: lbs

☐ Yes ☐ No Does your child have any health related problems?

If yes, explain: _____

Parents' current marital status:

☐ Married to each other for years

☐ Separated for years

☐ Divorced for years

☐ Mother remarried times

☐ Father remarried times

☐ Mother involved with someone

☐ Father involved with someone

☐ Mother deceased for years

Child's age at time of mother's death: _____

☐ Father deceased for years

Child's age at time of father's death: _____

List any other people living in your home at this time:

Name: _____ Age: _____ Relationship to child: _____
Name: _____ Age: _____ Relationship to child: _____
Name: _____ Age: _____ Relationship to child: _____
Name: _____ Age: _____ Relationship to child: _____
Name: _____ Age: _____ Relationship to child: _____
Name: _____ Age: _____ Relationship to child: _____

List other important family members or relatives living outside the home:

Name: _____ Age: _____ Relationship to child: _____
Name: _____ Age: _____ Relationship to child: _____
Name: _____ Age: _____ Relationship to child: _____
Name: _____ Age: _____ Relationship to child: _____
Name: _____ Age: _____ Relationship to child: _____

Which of the following describes your child's current living situation?

☐ Rent apartment ☐ Rent house ☐ Own house
☐ Foster care ☐ Condominium ☐ Shelter
☐ Homeless ☐ Group home ☐ Residential treatment

What is the primary language spoken in your home? _____
Mother's current employer/job title: _____
Father's current employer/job title: _____

FAMILY HISTORY

List the places your child has lived since birth, the dates they lived there, and with whom:

	Where:	With whom:	Dates (from-to):
1			
2			
3			
4			
5			

Have your child ever experienced any of the following?

☐ Yes ☐ No Physical Abuse Age/Describe: _____
☐ Yes ☐ No Sexual Abuse Age/Describe: _____
☐ Yes ☐ No Assault Age/Describe: _____
☐ Yes ☐ No Death of a parent Age/Describe: _____
☐ Yes ☐ No Death of a relative Age/Describe: _____
☐ Yes ☐ No Death of a friend Age/Describe: _____
☐ Yes ☐ No Parental separation Age/Describe: _____

FAMILY HISTORY

Please describe on both parents' side of the family any history of mental illness, suicide, legal problems, chemical abuse or dependency and physical/sexual abuse.

If it is someone else, describe his or her relationship to you (i.e. paternal uncle- alcoholic, mother- depression, etc):

Mother's side of the family:

☐ Yes ☐ No Alcohol abuse If yes, whom? _____
☐ Yes ☐ No Substance abuse If yes, whom? _____
☐ Yes ☐ No Mental Health problems If yes, whom? _____
☐ Yes ☐ No Physical abuse If yes, _____

whom? _____

☐ Yes ☐ No Sexual abuse If yes, whom? _____

Father's side of the family:

☐ Yes ☐ No Alcohol abuse If yes, whom? _____

☐ Yes ☐ No Substance abuse If yes, whom? _____

☐ Yes ☐ No Mental Health problems If yes, whom? _____

☐ Yes ☐ No Physical abuse If yes, whom? _____

☐ Yes ☐ No Sexual abuse If yes, whom? _____

Other issues currently affecting family members:

☐ Yes ☐ No Health problems If yes, describe: _____

☐ Yes ☐ No Disabilities If yes, describe: _____

☐ Yes ☐ No Legal issues If yes, describe: _____

☐ Yes ☐ No Financial concerns If yes, describe: _____

CHEMICAL HEALTH

Are you aware of or do you suspect any chemical use by your child?

☐ Yes ☐ No Cigarettes Describe: _____

☐ Yes ☐ No Alcohol Describe: _____

☐ Yes ☐ No Marijuana Describe: _____

☐ Yes ☐ No Inhalants Describe: _____

☐ Yes ☐ No Methamphetamines Describe: _____

☐ Yes ☐ No Cocaine/Crack Describe: _____

☐ Yes ☐ No Acid/LSD Describe: _____

☐ Yes ☐ No Other Describe: _____

☐ Yes ☐ No Previous chemical use problems Describe: _____

☐ Yes ☐ No Has your child ever had any chemical assessment done? If yes, when? _____

☐ Yes ☐ No Has your child ever had chemical dependency treatment? If yes, when? _____

Describe the parental use of drugs or alcohol at this time:

MOTHER

☐ Yes ☐ No Cigarettes Describe: _____

☐ Yes ☐ No Alcohol Describe: _____

☐ Yes ☐ No Marijuana Describe: _____

☐ Yes ☐ No Inhalants Describe: _____

☐ Yes ☐ No Methamphetamines Describe: _____

☐ Yes ☐ No Cocaine/Crack Describe: _____

☐ Yes ☐ No Acid/LSD Describe: _____

☐ Yes ☐ No Other Describe: _____

☐ Yes ☐ No Previous chemical use problems Describe: _____

☐ Yes ☐ No Previous chemical dependency treatment: Describe: _____

FATHER

☐ Yes ☐ No Cigarettes Describe: _____

☐ Yes ☐ No Alcohol Describe: _____

☐ Yes ☐ No Marijuana Describe: _____

☐ Yes ☐ No Inhalants Describe: _____

☐ Yes ☐ No Methamphetamines Describe: _____

☐ Yes ☐ No Cocaine/Crack Describe: _____

☐ Yes ☐ No Acid/LSD Describe: _____

☐ Yes ☐ No Other Describe: _____

☐ Yes ☐ No Previous chemical use problems Describe: _____

☐ Yes ☐ No Previous chemical dependency treatment: Describe: _____

SCHOOL

Name of the school your child attends: _____ Grade: _____

Teacher/case manager: _____

☐ Yes ☐ No Do you feel the school meets your child's needs?

☐ Yes ☐ No Do you have regular contact with their teachers?

☐ Yes ☐ No Is your child receiving special education services?

☐ Yes ☐ No Was your child ever retained a grade?

☐ Yes ☐ No Does your child participate in extracurricular activities at school?

☐ Yes ☐ No Does your child struggle academically at school?

☐ Yes ☐ No Does your child have behavior problems at school?

☐ Yes ☐ No Has your child ever been suspended or expelled from school?

☐ Yes ☐ No Does your child miss school regularly?

How many days of school has your child missed this school year? _____

How many days of school did your child miss the previous year? _____

Highest educational level reached by parents: Mother: _____

Father: _____

SUPPORTIVE FACTORS

List any previous mental health services your child has received:

	Clinic Name:	Therapist Name:	Dates:	Was it helpful?
1				☐ Yes ☐ No
2				☐ Yes ☐ No
3				☐ Yes ☐ No
4				☐ Yes ☐ No

☐ Yes ☐ No Does your child have a probation officer?

☐ Yes ☐ No Does your child have a County Social Worker?

☐ Yes ☐ No Does your child have a Guardian ad Litem (GAL)?

☐ Yes ☐ No Does your child have any other service providers?

Describe: _____

☐ Yes ☐ No Has your child ever been placed outside the home?

	Where:	Dates:
1.		
2.		
3.		
4.		

Who are the people or services that you find supportive to you and your family (i.e. church, relatives)? Please be specific.

_____

_____

Describe the role of religious and/or spiritual influences on your family:

_____

Describe any extracurricular activities you have or recreational hobbies you participate in:

Please check any areas that you may be concerned about:

- ☐ Depression
- ☐ Anxiety
- ☐ Not Following Rules
- ☐ Bedwetting/Soiling
- ☐ Learning Difficulties
- ☐ Truancy
- ☐ Fighting
- ☐ Stealing
- ☐ Fire Setting
- ☐ Hot Temper
- ☐ Crying a lot
- ☐ Physical Abuse
- ☐ Nightmares
- ☐ Weight Loss
- ☐ Promiscuity
- ☐ Chemical Use
- ☐ Lack of Friends
- ☐ Panic Attacks
- ☐ Violent
- ☐ Destroys Things
- ☐ Sexual Abuse
- ☐ Running away from home
- ☐ Excessive Worrying
- ☐ Strange Behaviors
- ☐ Suicidal thoughts/plans
- ☐ Hyperactivity
- ☐ Avoid Others
- ☐ Self Injurious Behavior
- ☐ Vandalism
- ☐ Physical problems with no known medical cause
- ☐ Obsessive Thoughts
- ☐ Obsessive Behaviors
- ☐ Gender Confusion
- ☐ Paranoia
- ☐ Odd beliefs
- ☐ Perfectionist
- ☐ Gang Involvement
- ☐ Mood Changes
- ☐ Doesn't Pay Attention

Please elaborate about anything you mentioned above that you are concerned about/any other stressors you are dealing with:

YOUR CHILD'S STRENGTHS (Check all that apply)

- ☐ Stays Active
- ☐ Independent
- ☐ Helpful
- ☐ Share with Others
- ☐ Good Looking
- ☐ Athletic
- ☐ Structures Time Well
- ☐ Liked by Adults
- ☐ Gets Along with Parents
- ☐ Employed
- ☐ Positive Outlook
- ☐ Easy Going
- ☐ Maintain Friends
- ☐ A Leader
- ☐ Liked by Others
- ☐ Responsible
- ☐ Tells you where they are
- ☐ Volunteers
- ☐ Attend school/Work Regularly
- ☐ Spiritual
- ☐ Intelligent
- ☐ Liked By Peers
- ☐ Has a hobby
- ☐ Structure Time Well
- ☐ Good Health
- ☐ Gets Along with Siblings
- ☐ Involved with Positive Adults
- ☐ Cope with problems well
- ☐ Humorous
- ☐ Caring
- ☐ Playful
- ☐ Artistic
- ☐ Responsible
- ☐ Positive view of the world
- ☐ Does Homework

Others

FAMILY STRENGTHS (Check all that apply)

- ☐ Parents Employed
- ☐ Clear Rules at Home
- ☐ Sense of Humor
- ☐ Knows Child's Friends
- ☐ Consistent Parenting
- ☐ Know How Child is Doing at School
- ☐ Go on Vacations Together
- ☐ Relatives Involved with Child
- ☐ Good Support Network
- ☐ Volunteer in Community
- ☐ Parents Get Along
- ☐ Strong Ethnic/Cultural Identity
- ☐ Often Eat Supper Together
- ☐ Do Activities Together
- ☐ Involved at Child's School
- ☐ Help Children with Problems
- ☐ Know Parents of Child's Friends
- ☐ Children have Jobs in the Home
- ☐ Attend Church
- ☐ Caring
- ☐ Resilient
- ☐ Good Communication
- ☐ Able to Show Affection

Others
:

What would you like to see come out of services for your child?

Is there any other information that would be helpful to know in helping your child?

COMPLETED BY: _____ DATE: _____

Relationship to child: _____