Patient Name:

DOB:

MR #:

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Date: _____

UW Health
(University of Wisconsin Hospitals and Clinics Authority)

CHILD, ADOLESCENT AND FAMILY QUESTIONNAIRE

Child's name: _____ Date of Birth: _____

Referring provider: _____ Pediatrician: _____

Name of person completing form: _____ Relationship: _____

Reason for seeking help:

_____

_____

_____

Previous counseling or treatment: ☐ Yes ☐ No

☐ Inpatient ☐ Outpatient ☐ Other

If yes, please describe including therapist/doctor, outcome, and date of treatment: _____

_____

_____

Has this child ever harmed or threatened to harm themselves? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Is there a history of legal action related to this child such as custody/visitation issues, probation, adoption, or child protective services? ☐ Yes ☐ No

_____

_____

_____

☐ Fighting
☐ Suspension
☐ Gang influence
☐ Lack of friends
☐ Learning disabilities
☐ Incomplete homework
☐ Drugs/Alcohol
☐ Poor attendance
☐ Behavioral problems
☐ Detention
☐ Poor grades

Patient Name:

DOB:

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UW Health
(University of Wisconsin Hospitals and Clinics Authority)
CHILD, ADOLESCENT AND FAMILY QUESTIONNAIRE

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PRENATAL AND DEVELOPMENT

Pregnancy:

☐ Yes ☐ No Full term? If not, how many weeks? _____

☐ Yes ☐ No Any complications or physical injuries during pregnancy? Describe: _____

_____

☐ Yes ☐ No Was the child's mother on any medication? Specify: _____

_____

☐ Yes ☐ No Was the child's mother exposed to alcohol, drugs, smoking, or toxic substances while pregnant?

Specify: _____

Labor:

☐ Yes ☐ No Normal delivery? If no, explain: _____

_____

_____

☐ Yes ☐ No C-Section: emergency, planned, repeat? Describe: _____

_____

_____

Apgar Scores: _____/_____

☐ Yes ☐ No Other problems? _____

Birth:

Birth weight: _____ lbs. _____ oz.

☐ Yes ☐ No Jaundice?

☐ Yes ☐ No Was the child hospitalized in the NICU after the mother was discharged? Why?

_____

_____

Infancy and Early Childhood:

Who were the primary caregivers during infancy and early childhood?

_____

_____

☐ Yes ☐ No Did any of the child's primary caregivers experience depression, anxiety, or other emotional problems?

Describe: _____

Describe parent's reaction to birth: _____

☐ Yes ☐ No Did the child experience feeding problems? Describe: _____

_____

Patient Name:

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CHILD, ADOLESCENT AND FAMILY QUESTIONNAIRE

How would you describe the baby's temperament (happy, tense, easy going, always crying, soothable, other)? _____

☐ Yes ☐ No Was this child unusually sensitive to clothing, movement, touch, light, etc.? _____

☐ Yes ☐ No Did this child become over-stimulated in a noisy environment? _____

☐ Yes ☐ No Any significant events during this child's life that could cause unhappiness, nervousness, or placed the child or parent under above normal stress or strain? _____

_____

Milestones:

☐ Yes ☐ No Did you ever have concerns about this child's development? Please explain: _____

_____

_____

Indicate if this child had/has any of the following:

Serious infection:	☐ Yes	☐ No	Age: _____
Convulsions:	☐ Yes	☐ No	Age: _____
Head injuries:	☐ Yes	☐ No	Age: _____
Other injuries:	☐ Yes	☐ No	Age: _____
Hospitalizations:	☐ Yes	☐ No	Age: _____
Surgery:	☐ Yes	☐ No	Age: _____
Ear infections:	☐ Yes	☐ No	Age: _____
Poisoning:	☐ Yes	☐ No	Age: _____
Allergies:	☐ Yes	☐ No	Age: _____
Asthma:	☐ Yes	☐ No	Age: _____
Alcohol use:	☐ Yes	☐ No	Age: _____
Drug use:	☐ Yes	☐ No	Age: _____
Sexual problems:	☐ Yes	☐ No	Age: _____
Medication allergies:	☐ Yes	☐ No	Age: _____

If you answered "yes" to any of the above, please explain further: _____

_____

Past Medications

Name	Dose	Reason for taking	When started	Why stopped

Current Medications

Name	Dose	Reason for taking	Why started

Patient Name:

DOB:

MR #:

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CHILD, ADOLESCENT AND FAMILY QUESTIONNAIRE

Family Information:

Is there any psychiatric illness in the family? ☐ Yes ☐ No

Explain: _____

Who lives in the same household as the child?

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Are the child's parents: ☐ Married ☐ Divorced ☐ Separated ☐ Never married ☐ Deceased

Has there been any abuse of this child?

Physical:	☐ Yes	☐ No
Emotional:	☐ Yes	☐ No
Sexual:	☐ Yes	☐ No
Neglect:	☐ Yes	☐ No

If yes, please briefly explain: _____

_____

Who has legal custody? _____

Has this child ever been in foster care? ☐ Yes ☐ No

_____

Signature of Patient/Representative: _____ Date: _____/_____/_____Time: _____

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

- Patient is: ☐ Minor ☐ Incompetent/Incapacitated
- Legal Authority: ☐ Legal Guardian ☐ Parent of Minor
  ☐ Health Care Agent ☐ Other: _____

Reviewed by: _____ Date: _____/_____/_____Time: _____