PPS
Practical Psychiatric Solutions

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Child & Adolescent Background Questionnaire

Purpose of this questionnaire: The purpose of this questionnaire is to obtain a comprehensive "picture" of your child/adolescent's background. In mental heath, obtaining background information is often necessary, as it permits a more thorough understanding of present difficulties. By completing these questions as fully and as accurately as you can, you will help your child's treatment.

Date: ___/___/___ Parent/Guardian: _____ Relation: _____

Child's Name: _____

Address: _____

DOB: ___/___/___ Age: _____ Gender: ☐ Male ☐ Female

What are your current concerns about your child? _____

_____

Why is treatment being sought at this time? _____

_____

How long has your child been having these difficulties? _____

Why do you think your child is having these difficulties? _____

_____

_____

Please check the severity of your child's difficulties:

☐ mild ☐ moderate ☐ severe ☐ extremely severe ☐ totally incapacitating

Are there situations at home that might be contributing to your child's difficulties? _____

_____

_____

Has your child threatened or attempted to harm themselves or others? ☐ Yes ☐ No

If yes, please explain: _____

Whose idea was it to have your child brought for help? _____

_____

What are your (and/or your child's) goals for treatment at this time? _____

_____

_____

Family Information

Mother's Name: _____ Age: _____

Address: _____

Home phone: (_____) _____ Work phone: (_____)_____ Other: (____)_____

Please check one: ☐ Biological mother ☐ Adoptive mother ☐ Foster mother ☐ Legal guardian

Marital Status: ☐ Single ☐ Married to child's father ☐ Separated ☐ Divorced ☐ Widowed

☐ Living together ☐ Other: _____

Employed? ☐ No ☐ Yes Place of employment & job title: _____

. . .

Father's Name: _____ Age: _____

Address: _____

Home phone: (_____) _____ Work phone: (_____)_____ Other: (____)_____

Please check one: ☐ Biological mother ☐ Adoptive mother ☐ Foster mother ☐ Legal guardian

Marital Status: ☐ Single ☐ Married to child's father ☐ Separated ☐ Divorced ☐ Widowed

☐ Living together ☐ Other: _____

Employed? ☐ No ☐ Yes Place of employment & job title: _____

Name of Step Parent(s) if applicable: _____

. . .

Is your child adopted? ☐ No ☐ Yes If yes, age of child when she/he was adopted:_____

Does your child know of the adoption? ☐ No ☐ Yes

Who lives with the child? Please provide information about all those living in the household.

Name	Age	Gender (M/F)	Relationship to child
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____

Please list any siblings who do not live with the child:

Name	Age	Gender (M/F)	Relationship to child
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____

Medical Information

** Child's Primary Physician_____ Phone: (____)_____

Address: _____

Date child last saw physician: ____/____/___ Reason:_____

May we have permission to contact your child's physician to coordinate care? ☐ Yes ☐ No

If there is no regular physician, what do you do if the child needs to see a doctor?_____

_____

** Immunizations up to date? ☐ Yes ☐ No If no, please explain: _____

_____

Child's Height: _____ Weight: _____Appetite: ☐ Good ☐ Fair ☐ Poor

Please check: ☐ Recent weight gain? ☐ Loss? ☐ Does your child over-eat? ☐ Binge/☐ Purge?

Please provide information with regard to the most recent exams:

Exam	Age	Result
Last Vision Exam	___	_____
Last Hearing Exam	___	_____
Other (neurology, cardiology, e.g.)	___	_____

*** Girls: First Menstrual Period: ☐ Not yet ☐ Yes, Age_____ Any concerns?* _____

_____

*** Current medical conditions being treated by a physician:* _____

_____

*** Has your child ever had trauma to the head or a closed head injury? If yes, please explain:*

_____

*** Has your child ever experienced loss of consciousness? If yes, please explain*: _____

_____

_____

*** Please provide information about surgical procedures and/or hospitalizations for your child. Include dates & results if known:* _____

*** Medication (name/dose of prescription(s), over-the-counter, supplements or herbal medicines):*

_____

_____

*** Allergies (including allergies to medication):* _____

Developmental History

Pregnancy/Labor/Delivery: ☐ Full-term ☐ Pre-term Delivery: ☐ vaginal ☐ c-section

Pregnancy complications? ☐ No ☐ Yes _____

Prenatal exposure to drugs and/or alcohol? ☐ No ☐ Yes, please explain: _____

Complications at birth: ☐ No ☐ Yes _____

Birth Weight: _____ Length: _____ Maternal postpartum depression: ☐ No ☐ Yes

Any developmental delays or other concerns about your child's development? ☐ No ☐ Yes

If yes, please describe: _____

Infancy: (0 to18 months) - Please check any that apply:

☐ Medical problems ☐ Feeding problems ☐ Sleep problems ☐ Unusual fears

☐ Unusual response to others ☐ Parental illness ☐ Prolonged separations

☐ Separation difficulties ☐ Head banging or self-injury ☐ Other: _____

Toddlerhood: (18 to 36 months) - Please check any that apply:

☐ Aggression ☐ Tantrums ☐ Self-injury ☐ Control battles ☐ Unusual or intense fears

☐ Sleep problems ☐ Night terrors ☐ Sleeps in parental bed ☐ Prolonged Separations

☐ Separation Problems ☐ Parental illness ☐ Other: _____

Toilet trained: _____ First words: _____ Speaking sentences: _____

Preschool: (3 to 5 yrs) - Please check any that apply:

☐ Aggression ☐ Tantrums ☐ Self-injury ☐ Frequent injuries ☐ Unusual Fears

☐ Toileting difficulties ☐ Sleep problems ☐ Defiance ☐ Separation problems

☐ Prolonged Separations ☐ Parental illness ☐ Fire setting ☐ Animal cruelty

☐ Bedwetting ☐ Soiling of underwear ☐ Help with household tasks

Childhood (6 to12 yrs) - Please check any that apply:

☐ Medical Problems ☐ Aggression or self injury ☐ School changes ☐ School absences

☐ School refusal ☐ School suspensions ☐ Learning Problems ☐ School failure

☐ Family Discord ☐ Family moves ☐ Divorce ☐ Parental illness ☐ Parental death

☐ Sleep problems ☐ Day/night-time wetting ☐ Day/night-time soiling ☐ Over/under weight

☐ Fire setting ☐ Animal cruelty ☐ Defiance towards adults ☐ Police/legal problems

☐ Sexual behavior ☐ Friendship Problems ☐ Run away ☐ Physical abuse ☐ Sexual abuse

Language and Reading Skills: ☐ As expected ☐ Difficulties: _____

Coordination: Can… ☐ Ride a bike ☐ Catch a ball ☐ Write in cursive

Any other concerns or added information: _____

_____

_____

_____

Adolescence (13 to 18 yrs) - Please check any that apply:

☐ Medical Problems ☐ Aggression or self injury ☐ School changes ☐ School absences

☐ School refusal ☐ School suspensions ☐ Learning Problems ☐ School failure

☐ Family Discord ☐ Family moves ☐ Divorce ☐ Parental illness/death ☐ Sleep problems

☐ Weight gain or loss ☐ Bizarre behavior or ideas ☐ Defiance towards adults

☐ Police/legal problems ☐ Friendship Problems ☐ Sexual behavior ☐ Pregnancy

☐ Runaway/truancy ☐ Self-mutilation ☐ Physical abuse ☐ Sexual abuse

Please describe any other concerns you may have: _____

_____

Substance Abuse Information

Substance abuse? ☐ No ☐ Yes ☐ Suspected. If yes, or suspected, please describe: _____

_____

History of chemical/alcohol use: _____

Are there heavy drinkers in your family of origin? ☐ No ☐Yes, whom? _____

Anyone concerned about the youth's drinking/use of drugs? ☐ No ☐ Yes _____

Has your child had treatment for alcohol or other chemical dependencies? ☐ No ☐ Yes

If so, when and where? _____

_____

Please check any that apply. (Rarely=1xmonth / Often=once-twice per week / Very often=daily)

Past						Current				
Drug	*Never*	*Tried*	*Rarely*	*Often*	*Very often*	*Never*	*Tried*	*Rarely*	*Often*	*Very often*
Alcohol										
Marijuana										
Cocaine										
Crack										
Heroin										
Other opiates										
Sedatives										
Amphetamines										
Hallucinogens										
Ecstasy										
Other										

Mental Health History

Has anyone in the child's family had any psychological or psychiatric problems? ☐ No ☐ Yes

If yes, please describe: _____

_____

Has child ever been physically abused? ☐ No ☐ Yes _____

Has child ever been sexually abused? ☐ No ☐ Yes _____

Has there ever been a Protective Service case opened related to this child or family? ☐ No ☐ Yes

If yes, please describe_____

Sexual/Gender Issues (Describe any sexual activity or gender concerns you have about your child):

_____

_____

Has your child had previous counseling, therapy, or psychiatric treatment? ☐ *No* ☐ *Yes …*

☐ *Outpatient* ☐ *Partial hospital* ☐ *Residential program* ☐ *Crisis stabilization*

☐ *Case management/Wrap-around services* ☐ *Court-ordered treatment*

If yes, please specify where, when, & reason: _____

_____

_____

_____

Indicate whether your child is involved with any other Human Service Agency, as applicable:

☐ Department of Social Services ☐ Protective Services ☐ Detention/Jail ☐ Probation

Education

Name of School:_____ Phone # _____

Grade: ____ Teacher :_____ Counselor/Social Worker: _____

Does child receive tutoring outside of school? ☐ No ☐ Yes

** Has your child been tested (school, private) for special education or other reason? ☐ No ☐ Yes

**If yes, please describe outcome, services, certifications, etc:_____

_____

Describe your child's attitude toward school:_____

Describe your child's past/current behavioral adjustment in school:_____

_____

Describe any problems (social or academic) you think your child may have at school: _____

_____

_____

Please check any of the words that describe your child/adolescent (words they use, or your own):

☐ intelligent ☐ confident ☐ worthwhile ☐ ambitious ☐ sensitive ☐ loyal/trustworthy

☐ considerate ☐ hardworking ☐ persevering ☐ attractive ☐ good sense of humor

☐ worthless ☐ full of regrets ☐ unattractive ☐ unlovable ☐ inadequate ☐ confused

☐ ugly ☐ stupid ☐ naïve ☐ incompetent ☐ can't make decisions ☐ has violent thoughts

☐ has suicidal thoughts ☐ other:_____

Interests and Strengths

Please describe your child's hobbies or interests (past and present)? _____

_____

_____

Please describe your family strengths: _____

_____

_____

Thank you for taking the time to provide this important information, so that I may have a more thorough understanding of your reasons for seeking consultation for your child's difficulties.

— Thomas B. Henry, MD
Diplomate, American Board of Psychiatry and Neurology

Parent/Guardian Signature & Date: _____

(Optional) Child/Adolescent Signature & Date: _____

Physician Signature & Date: _____