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**CONFIDENTIAL**

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# CHILD ASSESSMENT QUESTIONNAIRE

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*To the best of your ability, please answer all of the questions. All the information that you provide in this questionnaire will remain strictly confidential.*

Date:   mm  /  dd  /  yy  

Referral: \_\_\_\_\_

Person Answering Questions: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

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## Child Personal Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Sex:  Male  Female Birthdate:   mm  /  dd  /  yy   Age: \_\_\_\_\_

Place of birth: \_\_\_\_\_ Citizenship: \_\_\_\_\_

Mother tongue: \_\_\_\_\_ Other Spoken Languages: \_\_\_\_\_

School: \_\_\_\_\_ School Tel: \_\_\_\_\_

Grade: \_\_\_\_\_ Home Room Teacher: \_\_\_\_\_

Principal: \_\_\_\_\_

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## Parent Relationship

Married  Common Law  Separated  Divorced

## Parent Information

### Mother

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Tel.: (     ) \_\_\_\_\_ Work tel.: (     ) \_\_\_\_\_ Ext \_\_\_\_

Mobile: (     ) \_\_\_\_\_ E-mail: \_\_\_\_\_

### Father

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Tel.: (     ) \_\_\_\_\_ Work tel.: (     ) \_\_\_\_\_ Ext \_\_\_\_

Mobile: (     ) \_\_\_\_\_ E-mail: \_\_\_\_\_

## Family History

Is this child closer to one parent than the other?     NO     YES     If yes, which? \_\_\_\_\_

Has this child ever experienced any parental separations, divorces, or death?     NO     YES

If yes, when? \_\_\_\_\_ How old was this child at the time? \_\_\_\_\_

Please describe the circumstances. \_\_\_\_\_

If parents are separated or divorced, who has custody of the child? \_\_\_\_\_

How often does the other parent see this child? (Check one)

Weekly or More Often      Once or Twice a Month      Few Times a Year      Never

What do you enjoy most about this child? \_\_\_\_\_

What do you find most difficult about raising this child? \_\_\_\_\_

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## Presenting Problems

**In your opinion, why are you seeking help for this child?**

*Describe as much detail as possible, including what exactly the problem is, who it involves, when it began, what else was going on in the child's life at that time, how frequently it occurs, what bothers you most about it etc...*

**What do you expect out of this therapy? What are your goals?**

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## Stresses

**List what you think are the Top 3 stresses in your child's life right now.**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

# Symptoms

What symptoms has the child been displaying lately?

Symptom	Yes	No	Comment
Hyperactive behavior	<input type="checkbox"/>	<input type="checkbox"/>	
Lack of Attention	<input type="checkbox"/>	<input type="checkbox"/>	
Memory Lapses (Short-term or Long-term)	<input type="checkbox"/>	<input type="checkbox"/>	
Defiance of Parent /Teacher	<input type="checkbox"/>	<input type="checkbox"/>	
Anger /Tantrums	<input type="checkbox"/>	<input type="checkbox"/>	
Social avoidance	<input type="checkbox"/>	<input type="checkbox"/>	
Aggressive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches or Migraines	<input type="checkbox"/>	<input type="checkbox"/>	
Insecurity/Fears of being alone	<input type="checkbox"/>	<input type="checkbox"/>	
Academic Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
Fears/Phobias	<input type="checkbox"/>	<input type="checkbox"/>	

# Education and School

Current Grade: \_\_\_\_\_ Current School: \_\_\_\_\_

Subject strengths: \_\_\_\_\_

Subject weaknesses: \_\_\_\_\_

Behavior at school: \_\_\_\_\_

Comments from teachers: \_\_\_\_\_

Has Been Retained a Grade in School      No      Yes \_\_\_\_\_

Has skipped a Grade in School      No      Yes \_\_\_\_\_

Has Difficulty with Reading      No      Yes \_\_\_\_\_

Has Difficulty with Math      No      Yes \_\_\_\_\_

Gets Poor Grades      No      Yes \_\_\_\_\_

Has Been Tested for Special Education      No      Yes \_\_\_\_\_

Dislikes Going to School      No      Yes \_\_\_\_\_

Is Absent from School Frequently      No      Yes \_\_\_\_\_

Do you have any concerns about the quality of this child's school or teachers?      No      Yes

If yes, when and why? \_\_\_\_\_

## **Family**

Please describe your child's relationship with his/her family members. (If applicable)

Name	Age	Rate 1- 10	Quality
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## **Medical History**

<b>Condition</b>	<b>Duration</b>	<b>Comments</b>

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## **Medical Symptoms**

**Please indicate whether this child currently has any of the following problems. If yes, describe how often.**

**Respiratory**

Frequent Colds      No      Yes \_\_\_\_\_

Chronic Cough      No      Yes \_\_\_\_\_

Asthma      No      Yes \_\_\_\_\_

Hay Fever      No      Yes \_\_\_\_\_

Sinus Condition      No      Yes \_\_\_\_\_

**Cardiovascular**

Shortness of Breath      No      Yes \_\_\_\_\_

Dizziness with Physical Exertion      No      Yes \_\_\_\_\_

Activity Limitation      No      Yes \_\_\_\_\_

Heart Murmur      No      Yes \_\_\_\_\_

**Gastrointestinal**

Excessive Vomiting      No      Yes \_\_\_\_\_

Frequent Diarrhea      No      Yes \_\_\_\_\_

Constipation      No      Yes \_\_\_\_\_

Stomach Pain      No      Yes \_\_\_\_\_

Nausea      No      Yes \_\_\_\_\_

**Genitourinary**

Urination in Pants/Bed      No      Yes \_\_\_\_\_

Pain while Urination      No      Yes \_\_\_\_\_





**Neurological**

**Seizures/Convulsion**    No    Yes    **If yes, describe.** \_\_\_\_\_

**Speech Defects**        No    Yes \_\_\_\_\_

**Accident Prone**        No    Yes \_\_\_\_\_

**Bites Nails**            No    Yes \_\_\_\_\_

**Sucks Thumb**         No    Yes \_\_\_\_\_

**Grinds Teeth**         No    Yes \_\_\_\_\_

**Has Tics/Twitches**    No    Yes \_\_\_\_\_

**Bangs Head**            No    Yes \_\_\_\_\_

**Bowel Movements in Pants/Bed**    No    Yes \_\_\_\_\_

**Has child ever taken tranquilizing medication?**        No    Yes

**If yes, when?** \_\_\_\_\_ **What medication?** \_\_\_\_\_

**Has child ever taken medication for ADD, ADHD, or similar problems?**        No    Yes

**If yes, when?** \_\_\_\_\_ **What medication?** \_\_\_\_\_

**Allergies**

**Allergy to Medicine**    No    Yes    **If yes, describe.** \_\_\_\_\_

\_\_\_\_\_

**Allergy to Food**        No    Yes    **If yes, describe.** \_\_\_\_\_

\_\_\_\_\_

**Other Allergies**        No    Yes    **If yes, describe.** \_\_\_\_\_

\_\_\_\_\_

**Hearing**

**Ear infections**         No    Yes \_\_\_\_\_

Hearing Problems    No    Yes \_\_\_\_\_

Ear Tubes            No    Yes \_\_\_\_\_

Date of Most Recent Hearing Exam \_\_\_\_\_

**Speech**

Stuttering            No    Yes \_\_\_\_\_

Unclear Speech      No    Yes \_\_\_\_\_

Other Speech Issues    No    Yes \_\_\_\_\_

Date of Most Recent Speech Exam \_\_\_\_\_

**Sleep**

How many hours does he/she sleep per night? \_\_\_\_\_

What time does he/she usually go to bed? \_\_\_\_\_

Does he/she have difficulty sleeping?  Yes  No

- If so, what is the difficulty:
- Falling asleep
  - Waking up throughout the night
  - No Sleep at all
  - Fears Sleeping alone
  - Other. Specify: \_\_\_\_\_
  - Nightmares
  - Early Wake Up
  - Bedwetting

Does your child feel or seem rested upon waking?  Yes  No

**Medical Care**

Child's Physician \_\_\_\_\_ Telephone \_\_\_\_\_

How often does this child see a doctor? \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Is this child currently on medication?            No    Yes

If yes, indicate type and reason \_\_\_\_\_

Is this child presently taking any vitamin or health supplements?    No    Yes

If yes, indicate type and reason \_\_\_\_\_

# Psychological History

Has this child ever had psychological counseling or therapy?      No      Yes

If yes, therapist's name \_\_\_\_\_

Date of Last Visit \_\_\_\_\_ Telephone \_\_\_\_\_

Reason for Consulting at the time \_\_\_\_\_

Does your family have a psychiatric history?    No    Yes \_\_\_\_\_

# Mood State

Using the scale below, where do you see your child right now? (Please circle your response)

1	2	3	4	5	6	7	8	9	10
No Anxiety. Relax and mellow most of the time.					Very Panicky. Highly Anxious.				

Using the scale below, where do you see your child right now? (Please circle your response)

1	2	3	4	5	6	7	8	9	10
Happy Joyful			Sad				Depressed Apathetic		

Has your child ever spoken about committing suicide?     Yes     No

*If Yes, please specify.*

# Diet

Consider what your child would eat on a typical day.

<b>Food</b>	<b>Yes</b>	<b>No</b>	<b>How Many Portions Per Day?</b>
Dairy (i.e. Milk, Yogurt, Cheese, etc...)	<input type="checkbox"/>	<input type="checkbox"/>	
Grains (i.e. Bread, Cereal, etc...)	<input type="checkbox"/>	<input type="checkbox"/>	
Vegetables	<input type="checkbox"/>	<input type="checkbox"/>	
Fruit	<input type="checkbox"/>	<input type="checkbox"/>	
Meat (i.e. Beef, Chicken, Turkey, etc...)	<input type="checkbox"/>	<input type="checkbox"/>	
Meat Alternatives (i.e. Soy based products, tofu, etc...)	<input type="checkbox"/>	<input type="checkbox"/>	
Fish (i.e. Salmon, Tuna, etc...)	<input type="checkbox"/>	<input type="checkbox"/>	
Caffeine (i.e. Chocolate, colas, coffee, tea, energy drinks)	<input type="checkbox"/>	<input type="checkbox"/>	
Candy, energy bars, protein shakes	<input type="checkbox"/>	<input type="checkbox"/>	

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## **Exercise**

Does your child exercise regularly?  Yes  No

<b>Type of Exercise</b>	<b>Frequency</b>	<b>Comments</b>

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## **Hobbies/Interests/Activities**

List some of your child's favorite hobbies, interests and activities.

Hobby/Interest/Activity	Frequency	Why does he/she enjoy this activity?

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## **Additional Comments**

Is there anything else you feel is important to share right now?

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## **Authorization to Release Confidential Information**

I understand that the health professionals at Clinique PsySanté use a multi-disciplinary team approach and may share pertinent information regarding my child's case with each other only. The purpose of this is solely to better serve the interests of my child/family. I authorize this sharing amongst the health professionals at PsySanté.

Signature of main custodial parent/legal guardian: \_\_\_\_\_

Date: \_\_\_\_\_

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**I understand that the Psychologist/ Practitioner involved in my child's case may need to communicate with another person(s) involved in my child's care (ex. physician, teacher, principal, coach, etc.).**

**I authorize my Psychologist/Practitioner, to share pertinent information regarding my child's file specifically to:**

**1.**

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<b>Name</b>	<b>Relationship</b>	<b>Address</b>	<b>Phone Number</b>
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**2.**

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<b>Name</b>	<b>Relationship</b>	<b>Address</b>	<b>Phone Number</b>
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**3.**

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<b>Name</b>	<b>Relationship</b>	<b>Address</b>	<b>Phone Number</b>
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**4.**

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<b>Name</b>	<b>Relationship</b>	<b>Address</b>	<b>Phone Number</b>
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**Signature of main custodial parent/legal guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_