Anxiety & OCD Center

Dr. Erwin Consulting®

CHILD CLINICAL HISTORY QUESTIONNAIRE

Patient Name _____ Date _____

Address _____ Email 1: _____

_____ Email 2: _____

Telephone (Home)_____ Is it OK for us to call you at this #? Yes No

(Work) _____ Is it OK for us to call you at this #? Yes No

(Cell) _____ Is it OK for us to call you at this #? Yes No

Date of Birth_____ Age_____ Grade _____Gender_____

Referral Source _____

Reason for Evaluation: _____

_____

List current psychotropic medications (dose, timeframe, prescriber):

_____

_____

_____

_____

_____

_____

_____

Person Completing Questionnaire:_____ Date: _____

Mother's Name:_____ Occupation:_____

Father's Name:_____Occupation:_____

Number of children living at home _____

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Physician's Name _____

Physician's Telephone # _____

Physician's Address _____

Psychiatrist's Name _____

Psychiatrist's Telephone # _____

Psychiatrist's Address _____

MARITAL AND FAMILY HISTORY

Parent's Marital Status: Married_____ Separated_____ Divorced_____ Widowed _____

If parents are separated or divorced, for how long?_____

Is either parent remarried? Yes___ No___ If yes, which parent and for how long? _____

What are the custody arrangements**?_____

****In cases of separation, divorce, and joint legal custody, both parents must sign a consent to treatment and policies.**

Please describe history of mental health issues or learning difficulties among family members:

Parents:_____

Siblings:_____

Mother's Family:_____

Father's Family:_____

PSYCHIATRIC HISTORY

Has your child ever received counseling or therapy? Yes ____No ____

If yes: Reason:_____

Has it been beneficial?_____

Name of therapist(s) and duration of treatment:_____

Has your child required inpatient or day treatment?:_____

Please list any previous psychotropic medications (dose, timeframe, prescriber):

_____

_____

SOCIAL HISTORY

In what leisure activities does your child engage (sports, art, music, collections, computer, television, reading)?

_____

Does your child relate comfortably with others? Yes_____ No_____

Is your child overly-sensitive in friendships? Yes_____ No_____

Approximately how many friends does your child have? _____

How does your child react to new experiences? Anxiously _____ With Pleasure _____ Eagerly _____

What issues frustrate your child?_____

How does your child react to frustration?_____

ANXIETY SYMPTOMS

List common worries and situations that trigger worry for your child:

_____

_____

What does your child do to cope with worry?

_____

_____

What do family members and loved ones do to help your child cope with worry?

_____

_____

MOOD SYMPTOMS

Describe your child's general mood (happy, sad, irritable, apathetic):_____

Does your child have thoughts of death, suicide, or harm towards others?_____

Does your child engage in cutting or other forms of self-mutilation?_____

Does your child experience hallucinations or delusions (hearing voices, seeing visions, unusual beliefs)?

_____

ATTENTIONAL SYMPTOMS

Would you describe your child as being: Overly active _____ Normally active _____ Sluggish _____

Is your child easily distracted?_____

Does your child daydream? _____

Can your child be impulsive (does things without thinking them through)?:_____

_____

How would you describe your child's judgment?_____

SENSORY/OCCUPATIONAL THERAPY SYMPTOMS

Has your child undergone an occupational therapy evaluation or treatment?_____

Dates:_____

Indicate areas of difficulty:	Comments
Sensitivity to touch	_____
Sensitivity to sound	_____
Sensitivity to smell	_____
Sensitivity to taste	_____
Calmed by deep pressure	_____
Calmed by twirling	_____
Calmed by swinging	_____
"Flapping" or "Stimming" behavior	_____

MEDICAL HISTORY

Please describe your child's physical health and whether there are chronic medical conditions: _____

_____

Please list current non-psychotropic medications (including vitamins or herbal remedies) and doses:

_____

EDUCATIONAL HISTORY

Has your child ever had psychological or educational testing?: _____

Nursery School:_____ Ages & years Attended: _____

Kindergarten: _____ Ages Attended: _____

Elementary School(s):_____ Grades Attended: _____

Middle School(s):_____ Grades Attended: _____

High School(s): _____Grades Attended: _____

Please note any areas of concern related to academic performance:_____

_____

Has your child ever repeated a year of school? _____

Please note areas of academic strength:_____

Please note areas of academic weakness:_____

Do you feel that your child is achieving to his/her ability? _____

DEVELOPMENTAL HISTORY

Please explain any complications during Pregnancy, Labor, or Delivery:

_____

Was your child's general health good at birth?_____

Did your child get onto a good sleeping and eating schedule as a baby?_____

Please describe your child's gross-motor development (i.e., sitting, crawling, walking):

_____

Please describe your child's fine-motor development (buttoning, tying, holding a pencil, using scissors, writing):

_____

Please describe your child's speech/language development:_____

Were there any problems with toilet training? _____