

Dear Parent:

In preparation for your child's/adolescent's upcoming evaluation, we ask that you complete the enclosed Client Information Questionnaire. We apologize that the form is quite lengthy. Please realize that collecting this information before the evaluation will help us to utilize the time available to your child's best advantage.

Oftentimes useful clinical impressions can be generated at the very first meeting. Please be aware, however, particularly for children and adolescents, that the evaluation process often entails several meetings before full diagnostic impressions are made.

You may find it helpful to review your child's baby book and other records in order to complete the questionnaire. Also, it is quite helpful to have copies of all past evaluations and any pertinent school records available at the evaluation.

If your child is over age 12, then he or she will be asked to complete a separate Teen Questionnaire that is kept confidential.

The first session will likely involve some time for your child to spend alone with the evaluator as well as some time spent together with you and your child or possibly some time spent separately with you depending on the circumstances and the flow of the evaluation.

Sincerely,

DGR Management, Inc.

**CLIENT INFORMATION QUESTIONNAIRE**  
ALL INFORMATION CONFIDENTIAL

**General Information:** Date \_\_\_\_\_

Child's name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Child's Legal Custodian \_\_\_\_\_ Home phone \_\_\_\_\_

Name of person completing this form \_\_\_\_\_ Relationship to child \_\_\_\_\_

Referring individual or agency \_\_\_\_\_ Phone \_\_\_\_\_

Father's name \_\_\_\_\_ Relationship if not biological \_\_\_\_\_

Mother's name \_\_\_\_\_ Relationship if not biological \_\_\_\_\_

Biological father's name and address if not living with child \_\_\_\_\_  
\_\_\_\_\_ Frequency of contact \_\_\_\_\_

Biological mother's name and address if not living with child \_\_\_\_\_  
\_\_\_\_\_ Frequency of contact \_\_\_\_\_

Name, address, and phone number of person responsible for the bill:

\_\_\_\_\_  
\_\_\_\_\_

List family members and all others in the home:

Name	Age/Date of Birth	Relationship	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If parents are separated, how old was child at time of separation? \_\_\_\_\_  
Length of separation \_\_\_\_\_ If divorced, date \_\_\_\_\_

List any other siblings (along with age and relationship) not in home:

\_\_\_\_\_  
\_\_\_\_\_

Please briefly describe your child's current medical, behavioral and emotional problems. Include age at which problems started and any recent stressors:

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What seems to help?

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Circle any of the following if they have been problems for your child:

Speech or language	Fearful	Slow learner
Coordination	Wets bed	Sad
Prefers to be alone	Bites nails	Stomach troubles
Fights with siblings	Sucks thumb	Angry
Fights with peers	Tantrums	Can't relax
Fights with adults	Nightmares	Lonely
Physically aggressive	Sleep	Feels inferior
Destroys property	Rocking	Suicidal thoughts
Cruel to animals	Head banging	Trouble with friends
Steals	Holds breath	Indecisive
Shy/timid	Poor appetite	Depressed
Reckless behaviors	Stubborn/willful	Nervous
Self injury	Overactive	Bowel problems
Odd habits/mannerisms	Impulsive	Obsessive
Lack of friends		

**Developmental History:**

Age of mother during pregnancy \_\_\_\_\_ Mother's health  good  fair  poor

Any medications during pregnancy (list) \_\_\_\_\_

Did mother smoke, drink alcohol or use substances during pregnancy? \_\_\_\_\_

Specify amounts, types, frequency \_\_\_\_\_

Any illness during or complications of pregnancy (specify)

Diabetes  Rh negative  Toxemia/pre-eclampsia  Other \_\_\_\_\_

Length of pregnancy \_\_\_\_\_ weeks Labor \_\_\_\_\_ hours

Birth weight \_\_\_\_\_ Type of delivery  vaginal  C-section

Any instruments/forceps (specify) \_\_\_\_\_

Any complications of delivery or birth defects \_\_\_\_\_

Was mother depressed or down after delivery? \_\_\_\_\_

Please describe child as an infant:

Pleasant  Fussy  Calm  Colicky  Irritable  Hard to manage

Any problems with sleep or feeding (describe) \_\_\_\_\_

**Developmental milestones:**

To the best of your recollection, please fill in the age at which your child began each of these behaviors:

Showed response to parent \_\_\_\_\_ Put several words together \_\_\_\_\_

Rolled over \_\_\_\_\_ Dressed self \_\_\_\_\_

Sat alone \_\_\_\_\_ Toilet trained Bladder \_\_\_\_\_  
Bowel \_\_\_\_\_

Crawled \_\_\_\_\_ Dry at night \_\_\_\_\_

Walked alone \_\_\_\_\_ Fed self \_\_\_\_\_

Babbled \_\_\_\_\_ Rode tricycle \_\_\_\_\_

Spoke single words \_\_\_\_\_

Have there been any caregivers other than parent prior to kindergarten?

Age	Setting	Child's reaction/behavior
_____	_____	_____
_____	_____	_____

### Medical History

Child's physician \_\_\_\_\_ Date of last exam \_\_\_\_\_

Please circle any of the following conditions your child has had and list dates or ages

Measles _____	Whooping cough _____
German measles _____	Meningitis _____
Mumps _____	Encephalitis _____
Chicken Pox _____	Seizures _____
Rheumatic Fever _____	Head injury _____
Broken Bones _____	Diabetes _____
Visual problems _____	Cancer _____
Hearing problems _____	Bleeding problems _____
Paralysis _____	Frequent nosebleeds _____
Severe/frequent headaches _____	Skin conditions _____
Extreme fatigue _____	Suicide attempt _____
Anemia _____	Bowel problems _____
Memory problems _____	Eating problems _____
Tuberculosis _____	Loss of consciousness _____
Fever above 105 _____	Dizziness/fainting _____

Is your child on a special diet? No Yes Describe \_\_\_\_\_

Does your child take any medications currently?  No  Yes

Please include any over the counter medications, herbal preparation, or supplements.

Drug	Dose	Frequency	Duration	Reason	Prescribed by
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In the past, has your child ever been on any medication for anxiety, depression, behavior problems, etc.?  No  Yes

Drug	Dose	Frequency	Effectiveness	Side Effects	Why discontinued
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Does your child have any drug allergies or sensitivities?  No  Yes

Drug	Symptom
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Does your child have any other allergies or sensitivities (environmental, food, dye, latex, etc.)?

No  Yes, describe \_\_\_\_\_

Caffeine consumption: (soda, tea, iced tea, coffee, etc.) amount \_\_\_\_\_ per day/week

Sexual development:

Has your child started developing sexual characteristics such as pubic hair or breast changes?

No  Yes

If yes, at what age and what was your child's attitude toward this? \_\_\_\_\_

\_\_\_\_\_

If applicable, age at first menstruation \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

Any menstrual irregularities, cramps, other physical discomfort?  No  Yes

**Child's Psychiatric History:**

Has your child ever received any mental health and/or substance abuse treatment?

ف No      ف In-patient      ف Out-patient

Place/Provider	Dates	Reason	Outcome

When was your child last seen by a mental health professional? \_\_\_\_\_ فN/A

Please list name and address of your family doctor and any other physicians or therapists involved in your child's care: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Significant events – please check and describe:

Event	Date	Describe
ف Loss of someone close	_____	_____
ف Loss of pet	_____	_____
ف Trouble with law	_____	_____
ف Living placement away from home	_____	_____
ف Physical abuse or neglect	_____	_____
ف Incest/sexual abuse	_____	_____
ف Emotional abuse	_____	_____
ف Held back in school	_____	_____
ف Moves	_____	_____

**Child's Education:** Grade \_\_\_\_\_

Name and address of school child presently attends:

\_\_\_\_\_ Phone \_\_\_\_\_  
 \_\_\_\_\_ Contact person \_\_\_\_\_

Please check what you feel describes your child in the following areas:

Attendance	<input type="checkbox"/> Rarely absent	<input type="checkbox"/> Sometimes absent	<input type="checkbox"/> Often absent
Ability	<input type="checkbox"/> Above average	<input type="checkbox"/> Average	<input type="checkbox"/> Below average
Relations with classmates	<input type="checkbox"/> Above average	<input type="checkbox"/> Average	<input type="checkbox"/> Below average
Behavior	<input type="checkbox"/> Above average	<input type="checkbox"/> Average	<input type="checkbox"/> Below average

Has your child ever been suspended or expelled?  No  Yes

If yes, describe \_\_\_\_\_  
 \_\_\_\_\_

Any difficulties with  Reading  Math  Spelling  Writing  Other

What, if any, special services have been provided for your child in school (speech/language, remedial reading, special classes, counseling, groups, occupational therapy)?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Any school refusal or avoidance?  No  Yes

Social/Extracurricular activities (list and comment):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Family History:**

Is there a family history of any of the following disorders? If so, please check and list family member on adjacent line:

- Depression \_\_\_\_\_  
 Manic-Depression (Bipolar) \_\_\_\_\_  
 Anxiety Disorders \_\_\_\_\_  
 Suicide Attempt \_\_\_\_\_  
 Autism \_\_\_\_\_  
 Attention Deficit/Hyperactivity Disorder \_\_\_\_\_  
 Tics \_\_\_\_\_  
 Learning Disorders \_\_\_\_\_  
 Mental Retardation \_\_\_\_\_  
 Alcoholism \_\_\_\_\_  
 Drug Abuse \_\_\_\_\_

Is there any family history of medical problems, including diabetes, heart disease, cancer, seizures, Alzheimer's, asthma, etc.?  No  Yes

Describe \_\_\_\_\_  
 \_\_\_\_\_

Parents' current marital status:

- Married and living together     Separated     Widowed     Mother remarried  
 Single, never married     Divorced     Living together     Father remarried

How would you describe your marital relationship?

- No difficulties     Occasional difficulties     Frequent difficulties

Describe significant marital problems and how they are viewed by both spouses:

Mother's view:

\_\_\_\_\_  
 \_\_\_\_\_

Father's view:

\_\_\_\_\_  
 \_\_\_\_\_

Any marital counseling?  No  Yes

If yes, when? \_\_\_\_\_

How many sessions? \_\_\_\_\_

Reason? \_\_\_\_\_

Outcome \_\_\_\_\_

**Parents' History:**

Biological Mother: Name \_\_\_\_\_  
 Birth date \_\_\_\_\_ Age \_\_\_\_\_  
 Occupation \_\_\_\_\_ Place of Employment \_\_\_\_\_  
 Education (highest level) \_\_\_\_\_  
 Please describe any problems growing up – particularly involving relationships/family:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Biological Father: Name \_\_\_\_\_  
 Birth date \_\_\_\_\_ Age \_\_\_\_\_  
 Occupation \_\_\_\_\_ Place of Employment \_\_\_\_\_  
 Education (highest level) \_\_\_\_\_  
 Please describe any problems growing up – particularly involving relationships/family:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please complete the following sections as appropriate.

Adoptive/Stepmother: Name \_\_\_\_\_  
 Birth date \_\_\_\_\_ Age \_\_\_\_\_  
 Occupation \_\_\_\_\_ Place of Employment \_\_\_\_\_  
 Education (highest level) \_\_\_\_\_  
 Please describe any problems growing up – particularly involving relationships/family:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Adoptive/Stepfather: Name \_\_\_\_\_  
 Birth date \_\_\_\_\_ Age \_\_\_\_\_  
 Occupation \_\_\_\_\_ Place of Employment \_\_\_\_\_  
 Education (highest level) \_\_\_\_\_  
 Please describe any problems growing up – particularly involving relationships/family:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Parents' History: (continued)**

Some managed care companies require we ask the following questions regarding cultural/spiritual issues. You may choose to respond or not respond.

- 1. With what ethnic/cultural/racial group do you identify? \_\_\_\_\_
- 2. What is your religious affiliation? \_\_\_\_\_
- 3. What role does your religion/spirituality play in your life?  
 Positive  Negative  Neutral
- 4. Are there any spiritual or cultural issues that you feel need to be taken into account in your treatment?     Yes     No    If yes, please identify \_\_\_\_\_

Please list any additional comments or concerns:

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\_\_\_\_\_

Signature

\_\_\_\_\_

Date

**CONFIDENTIAL**  
**Teen Questionnaire**  
 (To be filled out at office, separate from parent)

Please briefly describe any problems for which you are seeking help:

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Please check any of the following if they are problems for you:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Nervousness      | <input type="checkbox"/> Sexual Problems      | <input type="checkbox"/> Concentration      |
| <input type="checkbox"/> Depression       | <input type="checkbox"/> Self control         | <input type="checkbox"/> Suicidal thoughts  |
| <input type="checkbox"/> Anger            | <input type="checkbox"/> Memory               | <input type="checkbox"/> Homicidal thoughts |
| <input type="checkbox"/> Energy           | <input type="checkbox"/> Inferiority feelings | <input type="checkbox"/> Finances           |
| <input type="checkbox"/> Sleep            | <input type="checkbox"/> Appetite             | <input type="checkbox"/> My thoughts        |
| <input type="checkbox"/> Loneliness       | <input type="checkbox"/> Friends              | <input type="checkbox"/> Bowel troubles     |
| <input type="checkbox"/> Making decisions |   |   |

Current caffeine consumption – soda, coffee, tea, iced tea  No  Yes  
 Amount \_\_\_\_\_

Do you drink alcohol?  No  Yes  
 Type \_\_\_\_\_ Amount \_\_\_\_\_ Last drink \_\_\_\_\_

Do you use illicit drugs – marijuana, cocaine, etc.?  No  Yes  
 Type \_\_\_\_\_ Amount \_\_\_\_\_ Last Used \_\_\_\_\_

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Have you ever experienced unprotected sex, needle sharing, or blood transfusion?  
 No  Yes Describe \_\_\_\_\_

Sexual orientation:  Heterosexual  Homosexual  Bisexual  Uncertain

Do you use tobacco in any form?  No  Yes  
 Describe \_\_\_\_\_