CENTER FOR INTEGRATED
BEHAVIORAL HEALTH

NEW CLIENT QUESTIONNAIRE (Child/Adolescent)

Date_____

IDENTIFYING INFORMATION:

Child's Name: _____

DOB: _____ SS#_____ Gender M F

School: _____ Grade_____

If Special Education, please specify: _____

Mother's Name: _____Father's Name: _____

Legal Guardian's Name (if applicable): _____

Address: _____

City_____ State_____ Zip _____

Ethnicity _____ Religion _____

Home Phone _____ Can we leave a message at this number Y N

Parent's Work Phone _____Can we leave a message at this number Y N

Parent's Cell Phone _____ Can we leave a message at this number Y N

Parent's Email: _____May we contact you via email? Y N

How do you prefer to be contacted _____

INSURANCE INFORMATION:

Insurance Carrier: _____ ID#_____

Insurance Holder name: _____ Relation_____

Group#_____ Insurance Holder Date of Birth:_____

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FAMILY INFORMATION

Please list all individuals who are currently living in child's primary residence?

Person	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Mother's Occupation: _____

Father's Occupation: _____

Child's parents are (please circle)

Married/domestic partners divorced separated never married

DEVELOPMENTAL/MEDICAL HISTORY

Any pregnancy complications? Y N

If so please specify:

Child was born (Circle):

Pre-term by #_____days on time post term by #_____days

At what age did your child achieve these developmental milestones?

Crawling: _____ Walking: _____ Toilet Training: _____

Talking (single words): _____ (sentences): _____Any problems during the first year?

Excessive Crying Y N Hyperactivity Y N Sleeping Y N

Feeding Problems Y N Difficulty Bonding Y N Other:_____

Other important information about your child's development:

MEDICAL INFORMATION:

Primary Care Physician _____ Phone #: _____

Address _____

City _____ State _____ Zip_____

Please list medical problems (from infancy to present time):

_____

_____

_____

_____

_____

_____

_____

What are Present Concerns? Why are you seeking treatment at this time?

_____

_____

_____

_____

_____

_____

Medications

Medication	Dosage/Frequency	Condition	Prescribing Physician

PREVIOUS BEHAVIORAL HEALTH SERVICES: (Such as with a Psychologist, Social Worker, Psychiatrist, Counselor or Psychological testing).

With Whom	When	Type of Treatment	Were you hospitalized? Where?

Please check off which problems / symptoms apply to your child/adolescent currently:

_____ sad/depressed mood

_____ anxious/tense

_____ panic attacks

_____ angry outbursts

_____ withdrawn

_____ fatigue

_____ decreased appetite

_____ increased appetite

_____ excessive weight loss

_____ excessive weight loss

_____ excessive weight gain

_____ purging

_____ increased sleep

_____ difficulty falling asleep

_____ early morning waking

_____ nightmares

_____ hyperactivity

_____ stealing

_____ alcohol use

_____ drug use

_____ physical aggression/fighting

_____ problems with the law

_____ truancy

_____ suicidal thoughts

_____ suicide attempt

_____ suicide attempt

_____ self-injurious behavior (e.g. cutting)

_____ auditory hallucinations

_____ visual hallucinations

_____ inappropriate sexual behavior

_____ poor peer relationships

_____ poor family relationship

Please use this space to describe any other issues, questions, or concerns you have about your child/adolescent.

FAMILY MEDICAL HISTORY: Have your family members struggled with the following?

Depression	Y	N	Relative_____
Bi-Polar Illness	Y	N	Relative_____
Heart Disease	Y	N	Relative_____
Diabetes	Y	N	Relative_____
Dementia	Y	N	Relative_____
Schizophrenia	Y	N	Relative_____
Anxiety	Y	N	Relative_____
Eating Disorder	Y	N	Relative_____
AD/HD	Y	N	Relative_____
Seizures	Y	N	Relative_____
Alcohol/Drug Problem	Y	N	Relative_____
Asthma	Y	N	Relative_____
Blood Pressure	Y	N	Relative_____
Stroke	Y	N	Relative_____
Cancer	Y	N	Relative_____