Steven J. Covelluzzi, Psy.D.

Clinical Psychologist
PSY 24668

2333 Camino del Rio South, Suite 160
San Diego, California 92108
T: 619-342-4155
F: 619-694-4840
www.sjcbehavioralhealth.com
steven@sjcbehavioralhealth.com

Initial Child / Adolescent Questionnaire

Parent 1. INFORMATION

Parent 1's name: ___________________Date of birth: _______ Home phone: _____________

Address:____

Race/ethnicity: _____________________________ Religious affiliation:____________________

Highest Grade Completed: ____________________________________

Marital/relationship status (Check one):

__Married __Live with partner __Single __Separated/Divorced __Widowed __ Other: _______

Employment status (Check all that apply):

__employed __retired __disabled __student __homemaker __unemployed

If/When employed, what type of work does parent 1 do?

____

Current employer is:

____

Years on Current Job: __________________ Business Phone:___________________________

Is it OK to contact parent 1 at work? __ Yes __No OK to leave a message? __Yes __No

Special calling instructions?

____

Parent 2. INFORMATION

Parent 2's name: _______________Date of birth: ___________ Home phone: _____________

Address:

____

Race/ethnicity: ______________________Religious affiliation: ___________________________

Highest Grade Completed: ______________

Marital/relationship status (Check one):

__Married __Live with partner__ Single __Separated/Divorced __Widowed __ Other: ________

Employment status (Check all that apply):

__employed __ retired __disabled __student __homemaker __unemployed

If/When employed, what type of work does parent 2 do?
____

Current employer is:
____

Years on Current Job: ____________________ Business Phone:__________________________

Is it OK to contact parent 2 at work? Yes No OK to leave a message? Yes No

Special calling instructions?
____

If the parents of the child are separated or divorced:

How old was the child at the time?
Please describe the circumstances of the divorce:
Who has legal custody of the child?
What is the visitation schedule?
Are there any issues with the visitation schedule?
Has your child experienced any traumatic events?
Has your child been physically or sexually abused?
Has your child been evaluated by Child Protective Services? (CPS) If yes, who is the caseworker?

REASON FOR SEEKING TREATMENT

Please briefly describe the problem(s) your child is experiencing:
1.____
____
2.____
____
3.____

What has happened to cause you to seek help NOW?
____
____
____
____

What do you hope to be able to do or achieve as a result of treatment?

____

____

____

What kinds of stressful events has your child experienced recently?

____

____

____

What kinds of stressful events have family members experienced recently?

____

____

____

What do you consider to be other stresses in your child's life?

____

____

____

Birth History:

Y	N	Was your child a full-term pregnancy?
Y	N	If born before due date, how early? _______________Weeks
Y	N	How was the baby born? Vaginal or C-Section
Y	N	Were there any complications during the pregnancy?
Y	N	How much did the baby weigh at birth?
Y	N	Were there any drugs or alcohol used during pregnancy? If yes, please name:
Y	N	Were there any problems during labor/delivery or following birth?
Y	N	Was this child breast fed or bottle fed
Y	N	Was the child conceived via surrogacy?
Y	N	

Child / Adolescent's Developmental History:
(if the following was an issue, please explain)

Y	N	Did your child sit up by 8 months old?
Y	N	Did your child crawl by 10 months old?
Y	N	Did your child walk by 15 months old?
Y	N	Did your child speak single words or sentences by age 2?
Y	N	Did your child read simple words by age 6?
Y	N	Did your child cry frequently as an infant?
Y	N	Was your child difficulty to calm down as an infant?
Y	N	Did your child have frequent temper tantrums as an infant/ toddler?
Y	N	Did your child have colic as an infant?
Y	N	Was your child a picky or poor eater as an infant?
Y	N	Does your child have bowel/stool problems?
Y	N	Does your child have problems with bladder control?
Y	N	Does your child have problems falling asleep/staying asleep or waking up?
Y	N	Does your child have nightmares, night terrors or sleepwalk?
Y	N	Has your child ever had tics/nervous twitches or made noises/sounds?
Y	N	Did your child have problems getting along with others?

Y	N	Where there other problems experienced during the child's first year?

Child / Adolescent Medical History: (if yes, please explain)

Y	N	Has your child had major health problems?
Y	N	Has your child been hospitalized?
Y	N	Has your child had frequent ear infections?
Y	N	Has your child had vision or hearing problems?
Y	N	Has your child had a serious head injury or be unconscious?
Y	N	Has your child had seizures or epilepsy?
Y	N	Has your child ever had broken bones or fractures?
Y	N	Has your child ever had problems with growth/weight/appetite?
Y	N	Has your child ever had a surgery?
Y	N	Does your child have any allergies?
		Physician's Name / Address / Phone Number

HISTORY OF THE PROBLEM

When did your child first start experiencing the problem(s) that brought you to the clinic today?____

____

____

____

How often does the problem(s) occur?

____

How long does/has the problem last(ed)?

____

Does your child have any thoughts of harming him/herself? No Yes

Has your child ever attempted to harm him/herself? No Yes If yes, please explain:

____

____

Does your child have any thoughts of harming someone else? No Yes If yes, please explain:____
____
____

Has your child ever attempted to harm someone else? No Yes If yes, please explain:
____

Has your child ever had previous therapy/counseling of any kind? No Yes

If yes, when and for how long?
____

What was the name of the therapist your child met with?_____________________________

What concerns were addressed in therapy?
____
____
____

Was this experience helpful or unhelpful?_______________________________________
____

Has your child ever been hospitalized for emotional/behavioral problems? No Yes

If yes, when/where was this:
____
____

Has your child been prescribed medications to control emotional/behavioral problems? No Yes

If yes, please list medications, when prescribed, and by whom:

To your knowledge, has your child experimented with alcohol/drugs? No Yes

Are you concerned that your child might have or be developing a problem with alcohol or drugs?

If yes, please explain:
____

Areas of Concern: (Please Circle)

Academic Underachievement	Adoption	Anger Management
Anxiety	Attention Deficit/ Hyperactivity Disorder (ADHD)	Autism/ Asperger's Disorder
Blended Family	Chemical Dependency	Conduct Disorder / Delinquency
Depression	Divorce Reaction	Eating Disorder
Grief / Loss Unresolved	Low Self-Esteem	Mania / Hypomania
Medical Condition	Mental Retardation	Negative Peer Influences
Obsessive-Compulsive Disorder (OCD)	Oppositional Disorder	Panic/ Agoraphobia

Parenting Issues	Peer/ Sibling Conflict	Physical/ Emotional Victim
Posttraumatic Stress Disorder (PTSD)	Psychoticism (Hears Voices, Hallucinations)	Runway
School Violence	Sexual Abuse Perpetrator	Sexual Abuse Victim
Sexual Acting Out	Sexual Identity Confusion	Social Phobia/ Shyness
Specific Phobia	Suicidal/ Homicidal Ideation	ADD ANY ADDITIONAL CONCERNS IN THE BLANKS

What symptoms are related to this problem <u>currently</u>? Please circle all that apply to your child / adolescent: (if not indicated below, please write your own)

All children exhibit, to some extent, the behaviors listed below. Check those behaviors that apply to your child in excess or in exaggeration, when compared to other children of similar age.

Poor academic performance	Easily distracted	Impulsive	Failure to listen / follow through
Hyperactive/ easily looses things/ poor concentration	Makes carless mistakes	Speech delays / Oddities in speech pattern	Poor eye contact / Preoccupation with parts of objects
Rule driven / Rigid in thought / Misses non-verbal cues in conversation	Difficulty with social relationships / poor social skills	Refusal to comply with rules / Oppositional	Defiance toward parents / authority
Fights with others	Poor judgment	Lying / Lack of remorse	Sad / Depressed mood
Mood irritability	Thoughts of death / Suicide	Isolation from friends / family	Changes in eating patterns
Changes in sleeping patterns	Thoughts of worthlessness/ hopelessness	Excessive guilt	Low self-esteem / Cries easily / Self-disparaging remarks
Binge eating / Restricting food intake	Vomiting	Fears of gaining weight	Seeks excessively to please others
Fears rejection	Difficulty saying no to others	Loud / overly friendly	Inflated sense of self importance
Pressured speech	Disorganized in thoughts	Reduced need for sleep	Outlandish dress / poor personal grooming
Sexually acting out	Checking / rechecking	Compulsions	Intrusive thoughts
Illogical / bizarre thought process	Thinks someone is watching them	Shy around others	Avoids social situations
Hypersensitive to criticism	Afraid of specific objects	Avoids feared items / environments	Social withdrawal
Recent suicide attempt	Excessive worry / fear	Muscle tension	Feels on edge
Fears that something 'bad' is going to happen	Trouble falling asleep	Trembling / shaking	Shortness of breath / restlessness

Family History of:

			Mother	Father	Mother's Relative	Father's Relative
Y	N	Depression / Anxiety / Nervousness / Worries				
Y	N	Bipolar Disorder (Manic Depression)				
Y	N	Schizophrenia				
Y	N	Autism / Asperger's / Developmental Disorder				
Y	N	Tics or Tourette's Syndrome				
Y	N	Obsessive Compulsive Disorder (OCD)				
Y	N	ADHD / "Hyperactivity"				
Y	N	Substance or Alcohol Abuse				
Y	N	Learning Disability				
Y	N	Anger Management				
		Anorexia/ Bulimia/ Eating Disorder				
Y	N	Legal/ Law Problems				
Y	N	Head Injuries				
Y	N	Migraine Headaches				
Y	N	Stroke				
Y	N	Mental Retardation				

How well does your child work for short-term rewards?

____

How well does your child work for long-term rewards?

____

Does your child seem to create more problems, either intentional or not, within the home more than his/her siblings?

____

____

Does your child seem to learn from his/her mistakes or past experiences?

____

____

Types of discipline you use with your child:

____

____

Which disciplinary techniques seem to work best/are most effective?
____

Interests and Accomplishments, Hobbies/Talents (your child's):

Child's greatest accomplishment / reward?

Favorite activities?

What qualities / behaviors do you like most in your child?

School History

Were you concerned about your child's ability to transition and succeed in pre-school or kindergarten?

Rate your child's school related ACADEMIC learning:

	Good	Average	Poor
Nursery school			
Kindergarten			
Current grade			

To the best of your knowledge, at what grade is your child functioning?

Reading __________Spelling _________ Arithmetic ______Writing _____________

Please list any additional services your child is receiving currently (speech, IEP, Federal 504 accommodations plan, counseling):

Briefly describe any academic or school problems:

Please rate your child's school experience related to BEHAVIOR:

	Good	Average	Poor
Pre-school			

Kindergarten____

Current
grade____

Are there any other areas of concern that were not asked about?___________________________
____
____
____