ACAPS
Appalachian Counseling and Psychological Services, Inc.
One Oak Plaza, Suite 208 Asheville, NC 28801
Phone: 828-575-9760 Fax: 828-575-9761
https://www.acaps-nc.org

Patient Questionnaire & History

Child & Adolescent Form

Please print clearly & complete as thoroughly as possible

Today's Date: _____

Name of person completing this form: _____

Please list relationship to Patient: _____

Patient Demographics

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name:_____ Date of Birth: _____Age:_____

Biological Sex: Male / Female Gender Identity: Male / Female / Other:_____

Street/Mailing Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Child/Adolescent has lived at this address since:_____

Home Phone#: _____ Cell Phone#: _____

Is English patient's first/primary language? Yes / No If no, please list primary language: _____

Referral Source Information

Who referred patient to ACAPS for this evaluation? _____

Street Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Phone#: _____ Fax#: _____

Primary reason for referral: _____

_____

Medical Diagnosis (if applicable): _____

Family Information

Was the child adopted? Yes / No If yes, what type of adoption? _____

Approximate date child was adopted: _____ Age of child when s/he was adopted: _____

Who has custody? (*circle one*): *Mother and Father* / *Split custody* / *Mother only* / *Father only* / *Mother and significant other* / *Father and significant other* / *Legal guardian* / *Other*: _____

If custody is divided, how much time is spent with each parent/caregiver?

_____

Caregiver(s) that child spends the majority of the week living with (include Name(s) and Relation(s) to child):

_____

Number of sibling(s) patient has (Total): _____

Biological_____ # Half Sibling _____ # Other (*please specify*)_____

Additional people who live with the child, and their relations to the child:

_____

_____

Are there any current or pending legal or custody cases at this time? Yes / No

If yes please explain : _____

Is there currently any significant discord between family members? Yes / No

If yes, who is involved? _____

Is there family stress around transportation? Yes / No

Is there family stress around finances? Yes / No

Additional Comments (if applicable) :_____

Parent Information

Mother's Full Name: _____

Mother's Phone #(s): _____ Occupation: _____

Email(s):_____

Highest level of education completed: _____ Marital Status: *Married / In a relationship / Single Other:*_____

Mother's Address if different than child's:

Mailing Address: _____

City: _____ State: _____ Zip/Postal Code: _____

If the mother is not married to the father:

Mother's Significant Other's Name: _____

Phone #(s): _____ Occupation: _____

Highest level of education completed: _____

Father's Full Name:_____
Father's Phone #(s): _____ Occupation: _____
Email(s):_____
Highest level of education completed: _____ Marital Status: *Married / In a relationship / Single Other:*_____
Father's Address if different than child's:
Mailing Address: _____
City: _____ State: _____ Zip/Postal Code: _____

If the father is not married to the mother:

Father's Significant Other's Name: _____
Phone #(s): _____Occupation: _____
Highest level of education completed: _____

If there is a legal guardian: (Please note that **guardianship documents must be provided** along with this form):

Guardian's Name: _____
When was guardianship established?: _____ Type of Guardianship: _____
Are there plans to terminate guardianship? _____
Phone Number: _____ Occupation: _____
Email (s):_____
Mailing Address: _____
City: _____ State: _____ Zip/Postal Code: _____

Biological Parents' Medical History

Please check all items that apply for the **biological parents:**

Biological Mother:
___Alcoholism
___Anxiety
___Attention/Concentration problems
___Depression
___Drug abuse
___Hyperactivity
___Learning problems
___Moodiness
___Obsessive Compulsive Disorder
___Psychiatric hospitalization
___School problems

Biological Father:
___Alcoholism
___Anxiety
___Attention/Concentration problems
___Depression
___Drug abuse
___Hyperactivity
___Learning problems
___Moodiness
___Obsessive Compulsive Disorder
___Psychiatric hospitalization
___School problems

__Speech-Language Disorders
__Suicide
__Unreasonable fears (phobias)
__Other: _____

__Speech-Language Disorders
__Suicide
__Unreasonable fears (phobias)
__Other: _____

Additional Comments:
_____
_____

Pregnancy and Delivery

Duration of pregnancy (in weeks)_____ (e.g. full term = 40 weeks)
Type of labor: *Spontaneous / Induced* Duration (Hours: _____)
Type of delivery: *Vaginal / C-section*
Birth weight_____lbs _____oz

Please check all of the following problems that **occurred <u>during the pregnancy</u>:**

___Anemia
___Diabetes
___Excessive vomiting
___High blood pressure (hypertension)
___Infections
___Physical Injury
___RH incompatibility
___Spotting/bleeding
___Threatened miscarriage
___Toxemia
___Toxic exposure
___Trauma (physical/mental)
___X-rays during pregnancy
___Alcohol Consumption - If so, amount & frequency ?_____
___Substance use ? - If so, what type(s), amount, & frequency ? _____
___Smoking - If so, how many & how often ?
___Other (please explain): _____

Surgeries during pregnancy ? Yes / No

If so, please specify type and reason: _____

_____

Other illnesses during pregnancy: _____

_____

Medications and supplements taken during pregnancy:_____

_____

Other significant events, complications, or diagnostic procedures: _____

_____

Please check all complications that **occurred <u>during the delivery</u> or <u>immediately after</u>**:

___Birth injury
___Breech presentation
___Bruising
___Cord around neck
___Hemorrhage
____Jaundiced
___Meconium Aspiration Syndrome (MAS)
___Oxygen deprivation
Required transfusions
___Sepsis/Infection
___Use of forceps
___Vacuum extraction

If yes to any of the above complications, please explain issue **and** the treatment that was needed: _____
_____

Other complications? (If so, please explain):_____
_____

Following delivery, please provide total number of days child spent in hospital = _____

If child was admitted to neonatal intensive care unit (NICU) or if s/he required an Incubator: How many days did child spend in NICU /Incubator ? = _____

APGAR Scores (if known)=_____

Please check any and all complications that **occurred birth to 6 months:**

__Problems sucking
__Problems swallowing
__Feeding problems
__Problems breathing
__Seizures
__Problems growing
__Unusual stiffness
__Problems sleeping
__Diarrhea
__Excessive sleep
__Milk allergies
__Other allergies
__RH factor problem

Other complications? (If so, please explain):_____
_____
_____

Child's Medical History

Primary care doctor: _____ Office name: _____
Office#: _____ Fax#: _____

Please indicate if your child has received any of the following:
__CT Scan, if yes, date: _____
__fMRI, if yes, date: _____

___MRI, if yes, date: _____
___SPECT, if yes, date: _____
___PET, if yes, date: _____
___EEG, if yes, date: _____
___EKG, if yes, date: _____
___MEG, if yes, date: _____
___Spinal tap, if yes, date: _____

Please list **Medications and/or Supplements** that your child is *currently* taking to address medical concerns including **Dose** and **Reason for Medication**

Medication: Dosage: Reason for Medication:

1._____
2._____
3._____
4._____

Do you currently have any concerns about your child's ability to see? Yes / No

When was the last time you had your child's vision tested? Date: _____

Does your child use/require glasses or contact lenses? Yes / No

Do you currently have any concerns about your child's ability to hear? Yes / No

When was the last time you had your child's hearing tested? Date: _____

Has your child ever had pressure equalization tubes placed? Yes / No If so, at what Age(s)?: _____

Does your child use/require hearing aids? Yes / No

Does your child have a history of seizures? Yes / No If yes: With fever / Without fever

Frequency:_____ Causes:_____

Has your child ever been hospitalized for medical reasons? Yes / No If yes, please provide more details about the reason(s) and the date(s) of occurrence :_____

_____

_____

Has your child ever had any surgeries? Yes / No If yes, please provide the reason(s) and the date(s) of occurrence:_____

_____

Has your child ever had any serious head/brain/spinal cord injury/ies ? Yes / No

If yes, please provide more details about what happened and the date(s) of occurrence:_____

_____

Has your child ever lost consciousness? Yes / No If yes, please provide the context and duration:_____

_____

_____

Does your child have any known allergies or sensitivities? Yes / No If yes, please specify:_____

_____

_____

Please check all of the following health problems that your child has had and/or is currently experiencing (past, present) and list **Age(s) of occurrence**. Please mark "**C**" for current.

___Abdominal pain
___Abnormal gait
___Bedwetting
___Chronic diarrhea
___Chronic vomiting
___Cold, mottled skin
___Constipation
___Convulsions
___Course, dry hair
___Difficulty breathing
___Difficulty swallowing
___Dry, scaly skin
___Excessive appetite
___Excessive body hair
___Excessive sweating
___Excessive thirst
___Excessive weight gain
___Fainting spells
___Frequent headaches
___Head injury
___Hearing problems
___Hoarse cry
___Hyperactivity
___Irritability
___Itching of skin
___Joint or bone pains
___Large tongue
___Lump in neck
___Nausea
___Painful urination
___Pallor
___Palpitation of the heart
___Persistent cough
___Poor appetite
___Prominent eyes
___Puffy eyelids
___Restlessness
___Shortness of breath
___Sluggishness (lethargy)
___Stretch marks on skin
___Tremors
___Un-coordination
___Urinary frequency/urgency
___Visual difficulty
___Weakness
___Weight loss

Please check any and all of the following illnesses or conditions that your child has experienced and **Age(s) of occurrence**. Please mark "**C**" for current.

____Adrenal gland disorder
____AIDS/HIV positive
____Amputations
____Arteriosclerosis
____Diabetes
____Dizziness (e.g. vertigo)
____Encephalitis
____Endocrine problems
___Lupus
____Macular degeneration
____Meningitis
____Migraines

___Arthritis
___Asthma
___Blood disease (e.g. anemia)
___Bowl or bladder incontinence
___Brain aneurysm
___Brain/Spinal disorder
___Brain tumor
___Broken bones/fractures
___Bronchitis
___Cancer: _____
___Chronic ear infections
___Chronic fatigue syndrome
___Colon disease (e.g. Chron's, IBS)
___Concussion/head injury
___Cushing's syndrome
___Degenerative joint disease
___Epilepsy/seizures
___Fibromyalgia
___Gastro esophageal reflux Disease (GERD)
___Heart disease
___High blood pressure
___High cholesterol
___Hydrocephalus
___Hypoglycemia
___Hypothyroidism
___Irritable bowel syndrome
___Kidney disease
___Kidney disorder
___Liver disease
___Low testosterone
___Lung disease
___Movement disorder
___Multiple sclerosis
___Pancreatitis
___Parathyroid disorder
___Parkinson's disease
___Polio
___Regular urinary tract infection
___Stroke
___Swallowing disorder
___Thyroid disease
___Traumatic brain injury
___Tumor: _____
___Ulcer
___Other:_____

Has your child ever been exposed to any toxins, such as lead, mercury, solvents, etc.? Yes / No
If yes, please list what toxins:_____

Developmental Information

Were any of the following present to an unusual degree during the **first 6 years of life**?
Please check all that apply:

___Aggressive
___Clumsy, uncoordinated
___Colic
___Did/does not like to be held
___Difficult to console
___Disrupted sleep
___Drooling
___Easily agitated
___Eating problems
___Headaches
___Head banging
___High fevers
___Into everything, climbing
___Irritability
___Masturbation
___Nightmares
___Not calmed easily
___Poisoning/toxic exposure
___Poor weight gain
___Restless
___Unresponsive
___Unusually active
___Unusual number of accidents

Other:_____

Please indicate if any of these items are true regarding your child:

True / False - Did not drink from a cup by 12 months

True / False - Did not feed self by 18 months

True / False - Could not dress self by age 4

True / False - Not potty trained by 3 during days

True / False - Bed wetting at night past age 4

Information Regarding Sleep

On average, how many hours of sleep does your child get a night? _____

What time does your child *go to bed*? _____

What time does your child *go to sleep*? _____

What time does your child wake up in the morning? _____

Are bed/sleep and wake times consistent through the week? Yes / No Consistent on the weekend? Yes / No

How many hours of sleep did your child get last night? _____

Does your child have difficulty falling asleep?	Yes / No
Does your child have difficulty staying asleep?	Yes / No
Does your child have difficulty waking up?	Yes / No
Is your child groggy for an extended time when they wake up?	Yes / No
Does your child experience nightmares?	Yes / No
Does your child experience night terrors?	Yes / No
Does your child sleepwalk?	Yes / No
Does your child currently wet the bed?	Yes / No

Sensory/Motor Development

Please provide the closest *approximate* age your child reached these developmental milestones:

_____Smiled

_____Sat alone

_____Crawled

_____Stood

_____Walked alone

_____Ran

_____Ate finger foods

_____Fed self with spoon

_____Tied shoelaces

_____Buttoned clothes

_____Toilet trained

_____Slept through the night

_____Skipped/jumped
_____Rode a tricycle
_____Rode bicycle alone
_____Wrote name
_____Held bottle without help

The child is: Right Handed / Left Handed / Ambidextrous (uses both hands equally)

Has preferred handedness ever changed? Yes / No If yes, when did this occur? _____

Please indicate if your child currently has or previously had any of the following difficulties regarding *motor skills*.

___Difficulty learning to tie shoes
___Difficulty learning to ride a bike
___Poor fine motor skills
___Poor visual-spatial skills
___Poor sense of direction
___Poor balance/coordination
___Resists sports
___Resists physical activity

Please indicate if your child has presented with any of the following *sensory* difficulties:

___Talks incessantly
___Is easily startled
___Has muscle or verbal tics
___Is inflexible/stubborn
___Becomes upset when feet leave the ground
___Easily over-stimulated
___Doesn't like certain textures
___Has difficulty with transitions
___Over sensitive to sensory input
___Doesn't seem to notice when face/hands are messy
___Doesn't like tags in clothes
___Very picky about food
___Under-sensitive to sensory input
___Becomes upset at changes in routine
___Engages in repetitive behaviors

Has your child been *evaluated* by an occupational or physical therapist? Yes / No

If so, when did it occur ?_____

Who completed the assessment? _____

Has your child been provided occupational or physical therapy? Yes / No

If so, when did therapy occur ? _____

Who provided occupational or physical therapy ? _____

Speech/Language Development

Please provide the closest *approximate* **age** that your child reached these developmental milestones:

_____Said first words
_____Said 3-word sentence
_____Named colors
_____Recited ABC song

Please indicate if your child has or has had any of the following difficulties regarding *language skills*.

___Articulation problems
___Difficulty expressing self
___Has difficulty understanding what was said
___Has trouble describing things and people
___Word retrieval problems
___Following multi-step directions
__Asking for help
__Needs extra time to respond
__Seems to have trouble "finding the word" he/she wants to say
___Gets tongue-tied/disfluent
___Difficulty listening with distractions
___Retelling stories/experiences (i.e. putting them in order/giving details)
___Answering questions
___Getting to the point when talking
___Saying something another way when someone doesn't understand

How does your child usually communicate (check all that apply)?

□ gestures

□ single words

□ short phrases

□ sentences

Has your child been *evaluated* by a speech/language therapist? Yes / No

If so, when did it occur ?_____

Who completed the assessment ? _____

Has your child been provided speech/language (SPL) *therapy* ? Yes / No

If so, when did therapy occur ? _____

Who provided speech/language therapy ? _____

Social Development

Please indicate if your child has any of the following difficulties regarding *social skills*:

___Is bullied or teased	___Bullies or teases others	___Doesn't read cues well
___Feels rejected by peers	___Feels picked on by peers	___Doesn't get jokes/sarcasm
___Timing seems off	___Acts awkward around peers	___Doesn't grasp points of view

Academic Information

Name of school: _____

Address of school: _____

School Phone#: _____ School Fax#: _____

Teacher(s) Email Address(es): _____

Current grade: _____

Has your child had to repeat any grade level? (If yes, *please specify*): _____

How long has your child been attending this school? _____

Average amount of time spent on homework per night: _____hours

Did your child have any, or does child currently receive any of the following services? If so, please list **date(s)** of occurrence:

___IEP Testing	___504 Plan	___Tutoring
___IEP*****	___Tier II	___RTI
___Tier I	___Occupational therapy	___Tier III
___Speech pathology	___One-on-one assistance	___After-school care
___Behavior plan	___IQ Testing*****	___AIG program

___Other special services:

***please provide copy of document (e.g. IEP, IQ Testing) for ACAPS records.**

Please answer Yes or No to following questions regarding your child's school behavior:

Yes / No - Is your child reluctant to go to school?
Yes / No - Does your child deny problems with school or try to hide problems from you?
Yes / No - Does your child have a history of school phobia or fears related to school?
Yes / No - Does your child have nightmares related to school?
Yes / No - Does completion of homework require adult supervision or assistance?
Yes / No – Do school problems appear to be subject related?
Yes / No - Does your child have trouble making friends?
Yes / No - Do people often tell you your child is less mature than his/her same-age peers?
Yes / No - Is your child's activity level inappropriate for his/her age?
Yes / No - Is s/he picked on or bullied?
Yes / No - Did your child engage in biting behavior in preschool?
Yes / No - Is your child more defiant than his/her peers?

Please rate your child's school experience *related to academic learning:*

Preschool:	Good / Average / Poor
Kindergarten:	Good / Average / Poor
Grade school:	Good / Average / Poor
Middle school:	Good / Average / Poor
High school:	Good / Average / Poor
College:	Good / Average / Poor

Please rate your child's school experience *related to behavior:*

Preschool:	Good / Average / Poor
Kindergarten:	Good / Average / Poor
Grade school:	Good / Average / Poor
Middle school:	Good / Average / Poor
High school:	Good / Average / Poor
College:	Good / Average / Poor

Has/Have your child's classroom teacher(s) reported concerns regarding any of the following?:

___Attention/concentration
___Peer problems
___Following directions
___Distractibility
___Social problems
___Academic problems
___Activity level
___Withdrawal
___Handwriting
___Hyperactivity
___Aggression
___Not turning in assignments
___Learning problems
___Behavior problems
___Poor memory
___Low energy
___Other: _____

Please indicate if your child exhibits any of the following difficulties regarding *reading skills*:

___Difficulty learning the alphabet
___Poor tracking
___Reads slowly
___Resists reading
___Difficulty completing long passages
___Has difficulty remembering details of what's read
___Difficulty blending sounds
___Mispronunciations
___Reverses letters
___Poor recall
___Difficulty comprehending longer passages
___Has difficulty explaining what was read
___Unable to read smoothly
___Does not grasp the main idea
___Tires easily when reading
___Doesn't understand what is read
___Has trouble following written directions

Please indicate if your child has any of the following difficulties regarding *math skills*:

___Poor understanding of concepts
___Many careless errors
___Tires easily when doing math
___Doesn't show his/her work
___Difficulty doing steps in order
___Difficulty with basic facts
___Poor recall of concepts
___Difficulty holding numbers in their head
___Poor calculations
___Resists math
___Difficulty with spatial math

Please indicate if your child has any of the following difficulties regarding *writing skills*:

___Poor handwriting
___Resists writing
___Poor capitalization
___Problem with completion
___Difficulty getting thoughts on paper
___Poor spelling
___Writing below expectation
___Poor punctuation
___Difficulty starting assignments
___Difficulty communicating by writing
___Letter reversal
___Writing is laborious
___Poor grammar
___Difficulty organizing what to say

Community Information

Please indicate if your child participates in any of the following, including what *type* and *how often* they participate:

Community sports: Yes / No

What type? _____

How often? _____

Working out at the gym: Yes / No

What type? _____

How often? _____

Community activities (clubs, scouts, etc.): Yes / No

What type? _____

How often? _____

Backyard sports: Yes / No

What type? _____

How often? _____

Other: _____ Yes / No

What type? _____

How often? _____

What age group does your child tend to spend more time with?

At school: Younger / Same-age / Older / Prefers to be alone

In the neighborhood: Younger / Same-age / Older / Prefers to be alone

With family friends: Younger / Same-age / Older / Prefers to be alone

With siblings/family: Younger / Same-age / Older / Prefers to be alone

Please give the *approximate* hours/minutes your child spends each day doing the following:

_____Playing outside

_____Watching TV

_____Playing videogames

_____On the internet

_____Doing school-related homework

_____Playing with friends

Behavioral Concerns

Does your child have a history of running away? Yes / No

If yes, please describe:_____

_____

Does your child have a history of violent or aggressive behavior? Yes / No

If yes, please describe:_____

_____

Does your child have current or past history of involvement with legal authorities? Yes / No

If yes, please describe:_____

_____

Does your child have a history of substance abuse? Yes / No

If yes, please describe the type, amount, frequency, severity, and if/how the problem was dealt with:_____

_____

_____

Please indicate any and all behavior issues that your child may **currently** be exhibiting:

___Impulsive	___Overly physically active	___Can't sit still for long
___Difficulty organizing belongings	___Difficulty following directions	___Defiant or oppositional
___Avoids homework	___Forgetful	___Careless mistakes
___Loses things often	___Can't sustain attention for long	___Doesn't listen when spoken to
___Has difficulty waiting their turn	___Is easily distracted	___Fidgety or restless
		___Interrupts others

If above item(s) checked, please explain:

_____

_____

Are there any additional behaviors your child exhibits that have you concerned? Yes / No

If yes, please explain:_____

_____

Please check any and all guidance and disciplinary techniques that are used with the child in the home?

___Ignore problem behavior ___Verbal reprimand ___Spanking

___Redirect interests ___Reason with the child ___Time out

___Remove privileges ___Other:

Emotional Concerns

Has your child ever participated in therapy? Yes / No

If Yes, when? _____

Name of psychotherapist? _____

Has your child ever been placed in a psychiatric hospital? Yes / No

If Yes, how many times has your child required a psychiatric hospitalization? _____

If Yes, please provide approximate date(s) of occurrence? _____

Name of Provider / Location(s)? _____

_____

Are you worried about your child's self-esteem? Yes / No

If yes, please explain why:_____

_____

Are you worried about your child's moods or emotions? Yes / No

If yes, please explain why:_____

_____

Are you worried about your child's level of anxiety? Yes / No

If yes, please explain why:_____

_____

Has your child ever expressed any suicidal ideation or desires? Yes / No

If yes, please provide how often, when the most resent was, and any other relevant details:_____

_____

Has your child ever attempted suicide? Yes / No

If yes, please provide date(s), method(s), and any other relevant details regarding the event:_____

_____

Has your child ever experienced abuse? Yes / No

If yes, please provide when and what type:_____

_____

Has your child experienced the death of a close loved one? Yes / No

If yes, please provide who and when this occurred:_____

_____

Has your child ever experienced any difficult moves or transitions? Yes / No

If yes, please explain and provide dates:_____

_____

Miscellaneous Information

Please list any hobbies or activities that your child enjoys:_____

_____

_____

What would you say are your child's best traits?_____

_____

_____

Any addition information that you would like us to know about your child:_____

_____

_____