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.apppsych.org

Patient Questionnaire & History

Child & Adolescent Form

Please take the time to complete this questionnaire completely. This questionnaire helps the testing team with developing your child's testing plan. Additionally, history is useful to our understanding your child and interpreting your child's test results. Missing information and/or inaccurate information may lead to inaccurate conclusions and/or recommendations that are not useful to you. Please print clearly.

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: _____

_____

Has your child every participated in a psychological/neuropsychological evaluation?

If so, when ? _____ ***and where ?*** _____

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 and indicate which month/s</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: _____

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

Frequency:_____Causes:_____

If your child has been evaluated by a neurologist:
Doctor's name: _____ Office name: _____
Office#: _____ Fax#: _____

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
Does your child have a diagnosed vision issue, e.g., amblyopia, color-blindness ? Yes / No and who made that diagnosis ? _____ and when ? _____
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

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
__ COVID
___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
___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
___Diabetes
___Dizziness (e.g. vertigo)
___Encephalitis
___Endocrine problems
___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
___Lupus
___Macular degeneration
___Meningitis
___Migraines
___Movement disorder
___Multiple sclerosis
___Pancreatitis
___Parathyroid disorder
___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 and indicate at what age:

___Aggressive
___Clumsy, uncoordinated
___Colic
___Did/does not like to be held
___Difficult to console
___Eating problems
___Headaches
___Head banging
___High fevers
___Into everything, climbing
___Not calmed easily
___Poisoning/toxic exposure
___Poor weight gain
___Restless
___Unresponsive

___Disrupted sleep	___Irritability	___Unusually active
___Drooling	___Masturbation	___Unusual number of accidents
___Easily agitated	___Nightmares	

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

IF there were any delays in these areas, please provide the closest *approximate* age your child reached these developmental milestones:

_____Smiled
_____Sat alone
_____Crawled
_____Stood
_____Walked alone
_____Ran
_____Skipped/jumped
_____Rode a tricycle
_____Rode bicycle alone
_____Ate finger foods
_____Fed self with spoon
_____Tied shoelaces
_____Buttoned clothes
_____Toilet trained
_____Slept through the night
_____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
___Easily over-stimulated
___Doesn't like tags in clothes
___Is easily startled
___Doesn't like certain textures
___Very picky about food
___Has muscle or verbal tics
___Has difficulty with transitions
___Under-sensitive to sensory input
___Is inflexible/stubborn
___Over sensitive to sensory input
___Becomes upset at changes in routine
___Becomes upset when feet leave the ground
___Doesn't seem to notice when face/hands are messy
___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

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

***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
__Feels rejected by peers
__Timing seems off
__Bullies or teases others
__Feels picked on by peers
__Acts awkward around peers
__Doesn't read cues well
__Doesn't get jokes/sarcasm
__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 at school ? If so, please list **date(s)** or grades of occurrence:

___IEP Testing ***	___504 Plan	___Tutoring
___IEP ***	___Tier II	___RtI
___Tier I	___Occupational therapy	___Tier III
___Speech pathology ***	___One-on-one assistance	___ MTSS monitoring
___Behavior plan	___IQ Testing***	___AIG program
___Other special services:		

Has your child participated in tutoring outside of school ? If so, when and where ?

_____

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

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

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

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

Reading: Please indicate if your child exhibits or exhibited any difficulties with any of the following and when/what grade:

___Learning the alphabet	___Blending sounds	___Reading smoothly
___Tracking	__ Pronouncing words	___Grasping the main idea
___Reads slowly	___Reverses letters	

__ Remembering details of what's read

___Understanding longer passages

___Understanding sentences

__Explaining what was read

Does your child resist reading ?
Yes/ No

Math: Please indicate if your child has or had difficulties with any of the following and when/what grade:

___Understanding concepts

____Doing steps in order

___Learning basic facts

____Writing numbers

__ Recalling concepts

__Showing his/her work

___Holding numbers in their head

Does your child resist math?
Yes/ No

Writing: Please indicate if your child has or had difficulties with any of the following and when/what grade:

___Handwriting

___Spelling

___Letter reversals

___Completing written work on time

____Punctuation

___Grammar

___Getting thoughts on paper

__ Organizing what to say

Does your child resist writing ?
Yes/ No

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 been evaluated by a psychiatrist ? Yes / No

If Yes, when? _____

Name of psychiatrist? _____

**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 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:_____

_____

_____

*****You will likely be asked to provide copy of these records and/or to sign a release of information for ACAPS to receive these records**