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. 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: ____

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 the patient's first/primary language? Yes / No If no, list first/primary language: _______________

Referral Source Information

Who referred the patient to ACAPS for this evaluation? ____

Street Address: ____

City: ______________________________ State: _____________ Zip/Postal Code: ____________________

Phone#: ________________________________ Fax#: ______________________________________

Primary reason for referral: ____

____

Has your child ever participated in a psychological/neuropsychological evaluation?* If so, when? _____________________ and where? ____

*******You will need to provide a copy of the report along with this questionnaire or sign a release of information so that we can obtain it.***

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) the 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

Parent (1) Full Name: ____
Relationship to child (circle one): Biological / Adoptive / Legal. Circle one: Mother / Father
Phone #(s): ___________________________________ Occupation: ___________________________
Email(s): ____
Highest level of education completed: _______________
Marital Status: *Married / In a relationship / Single / Other:* _________________________
Name of significant other: __________________________________ *and relationship to child e.g., stepfather, stepmother, other* ________________
Address if different than child's:
Mailing Address: ____
City: ___________________________ State: _______________ Zip/Postal Code: ___________________

Parent (2) Full Name: ____
Relationship to child (circle one): Biological / Adoptive / Legal. Circle one: Mother / Father
Phone #(s): ________________________________ Occupation: __________________________
Email(s): ____
Highest level of education completed: _______________
Marital Status: *Married / In a relationship / Single / Other:* _______________________
Name of significant other: _______________________________ *and relationship to child e.g., stepfather, stepmother, other* _______________
Address if different than child's:
Mailing Address: ____
City: _________________________ State: __________________ Zip/Postal Code: ___________________

Parent (3) Full Name: ____
Relationship to child (circle one): Biological / Adoptive / Legal. Circle one: Mother / Father
Phone #(s): ________________________________ Occupation: __________________________
Email(s): ____
Highest level of education completed: _______________
Marital Status: *Married / In a relationship / Single / Other:* _______________________
Name of significant other: _______________________________ *and relationship to child e.g., stepfather, stepmother, other* _______________
Address if different than child's:
Mailing Address: ____
City: _________________________ State: __________________ Zip/Postal Code: ___________________

If there is a legal guardian: (Please note, **guardianship documents <u>must</u> 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:	*Biological Father:*
___Alcoholism	___Alcoholism
___Anxiety	___Anxiety
___Attention/Concentration problems	___Attention/Concentration problems
___Depression	___Depression
___Drug abuse	___Drug abuse

___Hyperactivity
___Learning problems
___Moodiness
___Obsessive Compulsive Disorder
___Psychiatric hospitalization
___School problems
___Speech-Language Disorders
___Suicide
___Unreasonable fears (phobias)
___Other: ____________________

___Hyperactivity
___Learning problems
___Moodiness
___Obsessive Compulsive Disorder
___Psychiatric hospitalization
___School problems
___Speech-Language Disorders
___Suicide
___Unreasonable fears (phobias)
___Other: _____________________

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: ______ pounds _______ounces

Please check all problems that occurred **during the pregnancy and indicate which month(s):**

___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, amount & frequency? _______
___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 **during the delivery** or **immediately after**:

___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 you answered yes to any of the above complications, please explain the issue and the treatment 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 **from 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 ALL **medications and/or supplements** that your child is **currently** taking:

	Medication:	Dosage:	Reason for Medication:	Prescribing Provider:
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 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 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#: __________________________

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-19

___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

____Diabetes
____Dizziness (e.g. vertigo)
____Encephalitis

____Lupus
____Macular degeneration
____Meningitis

____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 (Crohn's, IBS)
____Concussion/head injury
____Cushing syndrome
____Degenerative joint disease

____Endocrine problems
____Epilepsy/seizures
____Fibromyalgia
____Gastroesophageal 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

____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**?
If so, **please indicate at what age**:

___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 about 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 - 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

_____Ate finger foods

_____Fed self with spoon

_____Tied shoelaces

_____Buttoned clothes

_____Walked alone
_____Ran
_____Skipped/jumped
_____Rode a tricycle
_____Rode bicycle alone
_____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 with **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 ever been evaluated by a physical therapist? Yes / No

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

If so, when did it occur? ____

Who completed the assessment? ____

***Has your child been provided occupational therapy? Yes / No

If so, when did therapy occur? ____

Who provided the therapy? ________________________________

*****Please provide a copy of these records and/or sign a release of information for ACAPS to receive these records.**

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 (e.g. 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 therapy? Yes / No

If so, when did therapy occur? ____

Who provided speech/language therapy? ____

***** Please provide copy of these records and/or sign a release of information for ACAPS to receive these records**

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): ____

How long has your child been attending this school? ____

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

Average amount of time spent on homework per night: _______hours

Did your child have, or do they 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

*****Please provide copy of these records and/or sign a release of information for ACAPS to receive these records.**

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

____

Please answer Yes or No to the 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 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	___Understanding sentences
__ Remembering details of what was read	___Understanding longer passages	___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 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: _______________
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 behavioral 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)? ____

____

*****Please provide copy of these records and/or sign a release of information for ACAPS to receive these records.**

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, how recently, 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 additional information that you would like us to know about your child: __________________________
____
____

*****You are being asked to provide copy of records and/or to sign a release of information for ACAPS to receive records that we may need in order to proceed with creating a testing plan. A delay in receipt of records can delay the testing process.**