ACAPS
Appalachian Counseling and Psychological Services, Inc.
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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 <u>one</u>*): *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**:

<u>Biological Mother:</u>	*<u>Biological Father:</u>*
___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	___Excessive thirst	___Pallor
___Abnormal gait	___Excessive weight gain	___Palpitation of the heart
___Bedwetting	___Fainting spells	___Persistent cough
___Chronic diarrhea	___Frequent headaches	___Poor appetite
___Chronic vomiting	___Head injury	___Prominent eyes
___Cold, mottled skin	___Hearing problems	___Puffy eyelids
___Constipation	___Hoarse cry	___Restlessness
___Convulsions	___Hyperactivity	___Shortness of breath
___Course, dry hair	___Irritability	___Sluggishness (lethargy)
___Difficulty breathing	___Itching of skin	___Stretch marks on skin
___Difficulty swallowing	___Joint or bone pains	___Tremors
___Dry, scaly skin	___Large tongue	___Un-coordination
___Excessive appetite	___Lump in neck	___Urinary frequency/urgency
___Excessive body hair	___Nausea	___Visual difficulty
___Excessive sweating	___Painful urination	___Weakness
__ COVID-19		___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	____Diabetes	____Lupus
____AIDS/HIV positive	____Dizziness (e.g. vertigo)	____Macular degeneration
____Amputations	____Encephalitis	____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
___Peer problems
___Following directions
___Distractibility
___Social problems
___Activity level
___Withdrawal
___Handwriting
___Hyperactivity
___Aggression
___Not turning in assignments
___Learning problems
___Behavior problems
___Poor memory
___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
___Tracking
___Reads slowly
___ Remembering details of what was read
___Blending sounds
___ Pronouncing words
___Reverses letters
___Understanding longer passages
___Reading smoothly
___Grasping the main idea
___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 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.**