Karoll Counseling, LLC
744 Dulaney Valley Road, Suite 8B
Towson, MD 21204
443.535.3130

CHILD HISTORY QUESTIONNAIRE

CONFIDENTIAL

The purpose of this questionnaire is to obtain background data concerning your child. By completing this confidential form as fully as possible, you are assisting Carolyn Karoll, LCSW-C, with this evaluation and reducing the time required to meet with you to obtain this information. Your cooperation and patience is appreciated.

Date: _________________

Child's Name: ____ Birthdate ________________ Age: ________

Address:____

City: ______________________________________ State: ___________________________ Zip: _____________

How long at this address? _______________________________ Birthplace: _____________________________

Person completing this form: _____________________________ Relation to child: ________________________

REFERRAL INFORMATION:

Who referred you to this office, or how did you find out about me?

Name: ____ Phone number: __________________________

Address: ____

PRIMARY CONCERNS:

Please describe the problem(s) or concerns for which you are seeking help at this time:

____
____
____
____
____

When did the problem(s) first appear or begin? ____

Whom else have you consulted about your child's problem(s)? ______________________________________

What procedures have you tried on your own? ____

PRIOR TREATMENT

Has your child ever received inpatient or outpatient treatment or other services for this or other/related problems? Yes _____ No______

If yes, please list person(s) providing treatment in order, including names, addresses and phone numbers.

NAME	DATE	ADDRESS	PHONE #

What was your child's response to treatment? How would you describe the outcome?

____

____

PRIOR TESTING

Has your child received prior psychological testing? Yes _____ No______ Please bring or list results.

____

MEDICATION HISTORY

Has your child ever taken psychiatric medications? Yes _____ No______ If yes, please list.
Is your child on any other regular medications now? Yes _____ No____ If yes, please list.

	Drug Name	Drug Name	Drug Name	Drug Name
Prescribed by whom				
Date started/ended				
For what problems?				
Dose				
Benefits				
Side Effects				
Results				

PREGNANCY

While you were pregnant with this child, were you under a doctor's care? Yes _____ No______

Mother's age at time of birth? ________ years Father's age at time of birth? ________ years

Did mother smoke during pregnancy? Yes _____ No______ Drink alcohol? Yes _____ No______

Was this a planned pregnancy? Yes _____ No______ Which pregnancy for mother? (1st, 2nd, etc?) _____

DEVELOPMENTAL HISTORY:

At what age did child:

Sit alone	______	Say first word	______
Walk alone	______	Use two words together	______
Ride a tricycle	______	Become toilet trained:	
Dress self	______	--For day	______
Learn basic colors	______	--For night	______

If you responded yes to any of the above, please describe: ____

____

____

____

MEDICAL HISTORY

When did your child last have a physical examination? ____

Physician's Name ____ Phone ______________________

Physician's Address____

____

Does your child have past or current history of medical illnesses (e.g., seizures, thyroid problems, allergies)?

____ Yes ____ No

If yes, please describe: ____

____

____

____

Has your child been hospitalized? If yes, please describe: ____

____

How many times a week does your child exercise? __________What type & how many minutes? ___

What types of food does he/she often eat?

____

____

____

____

TEMPERAMENT: (Check all that apply)

Shy or timid	____	Fearful	____	Impulsive	____	Rocking	____
Stubborn	____	Cautious	____	Poor sleep	____	Headbanging	____
Affectionate	____	Underactive	____	Curious	____	Into everything	____
Temper outbursts	____	Overactive	____	Easy to manage	____	Slow to warm up	____
Dare devil	____	Happy	____	Aggressive		Poor eating	____
Wanted to be left alone		____		More interested in things than people			____

If you responded yes to any of the above, please describe: ____

____

____

Does your child play with (please circle all that apply):

Older children Younger children Same-age children

What problems does the child have at home? ____

____

When are these problems worse? ____

When are these problems better? ____

What important things have happened to child or family in the last 6 months? (e.g., death of a relative, divorce,

family crisis, etc.)? ____

____

Describe child's strengths: ____

____

Describe child's weaknesses: ____

____

What people does child feel close to? ____

Any sudden changes in child's mood or behaviors? If yes, explain: ___________________________

____

FAMILY INFORMATION:

Father's name: ___________________________ Age: __________ Education: ____________________________

Employment: ____ Work phone: __________________________

Type of work: ____ Home phone: _________________________

Mother's name: ___________________________ Age: __________ Education: ___________________________

Employment: ____ Work phone: __________________________

Type of work: ____ Home phone: _________________________

Other children in the home:

Name and age: __________________________________ Name and age: __________________________________

Name and age: __________________________________ Name and age: __________________________________

Name and age: __________________________________ Name and age: __________________________________

Other relatives or persons living in the home: ____

____

Siblings/half-siblings NOT living in the home: _______________________________________

____

Is your child adopted? Yes _____ No______

If yes, please describe the circumstances of the adoption: ______________________________

____

____

How long married ?_______________ If divorced, date of divorce: ____________________________

If separated, date of separation: _____________________ If unmarried, how long cohabitating? _____________

Any previous marriages? Describe: ____

____

FAMILY PSYCHIATRIC HISTORY:

Has the child's FATHER or FATHER'S relatives had similar or other psychiatric problems; for example mood problems, seizures/epilepsy, other neurological disease or disorder, learning problems, ADHD?

Yes________ No ________ If yes, please describe including treatment:__________________________________

____

____

Has the child's MOTHER or MOTHER'S relatives had similar or other psychiatric problems; for example mood problems, seizures/epilepsy, other neurological disease or disorder, learning problems, ADHD?

Yes________ No ________ If yes, please describe including treatment:__________________________________

____

____

Does the child's BROTHER(S) or SISTER(S) have any psychiatric problems?

Yes________ No ________ If yes, please describe including treatment:__________________________________

____

____

FAMILY MEDICAL HISTORY:

Is there any family history of medical illnesses (e.g., seizures, thyroid problems, allergies)? ____ Yes ____ No

If yes, please describe: ____

____

____

____

SCHOOL INFORMATION:

Name of school: ____ Phone #: __________________________

Teacher's name: ____ Grade: _____________________________

Type of school: Public: _______ Private: _______ Special: ________

List previous schools, dates attended and indicate overall performance, academic and behavioral:

School: ____ Dates: ___________________

Performance: Academic: Poor ____ Fair ____ Good ____ Behavioral: Poor ____ Fair ____ Good ____

School: ____ Dates: ___________________

Performance: Academic: Poor ____ Fair ____ Good ____ Behavioral: Poor ____ Fair ____ Good ____

School: ____ Dates: ___________________

Performance: Academic: Poor ____ Fair ____ Good ____ Behavioral: Poor ____ Fair ____ Good ____

School: ____ Dates: ___________________

Performance: Academic: Poor ____ Fair ____ Good ____ Behavioral: Poor ____ Fair ____ Good ____

Grades repeated ___________ Grades skipped __________ Expelled? Yes _____ No _______ # of times _____

Any known learning disabilities? If yes, explain: ____

____

____

Is your child in any special programs (speech, reading, etc.) Give names of tutors if relevant. If yes, explain:

____

____

How does the school describe your child's CLASSROOM behavior?: ___________________________________

____

____

What does your child do best in at school? ____

____

____

Which of the following problems, if any, does your child have in school?

_____ Does not do homework
_____ Fails to check homework
_____ Poor handwriting
_____ Poor reading skills
_____ Incomplete classroom work
_____ Does not remain seated
_____ Noncompliant in class
_____ Problems with written language
_____ Poor math skills
_____ Starts but does not finish homework
_____ Makes many careless errors
_____ Poor spelling
_____ Forgets assignments
_____ Excessive time to complete assignments
_____ Poor attention in class
_____ Talks out inappropriately in class
_____ Messy and disorganized

Describe any other problems around homework or academic functioning: ______________________________

____

Interactions with peers: _____ no friends _____ few friends _____ loses friends
_____ trouble making friends _____ mean, aggressive _____ too shy, timid
_____ bossy, controlling _____ plays well with peers

Further comments on peer relationships: ____

____

CHILD'S PERCEPTIONS/REACTION TO SEPARATION/DIVORCE (SKIP IF NOT APPLICABLE):

What is you child's reaction to the circumstances surrounding your separation/divorce?

____
____
____
____

What, if anything, have you told your child about the situation?

____
____
____
____
____

Does your child ask questions or talk about the separation or divorce? Yes No
If yes, what does your child seems most concerned about?

How do you think a separation or divorce will affect this child?

In what ways might he/she benefit from his/her parent's separation/divorce?

SIBLINGS, RELATIVES AND FAMILY FRIENDS:

Do you any worries or concerns about this child's relationships with his/her siblings? Yes No (skip if not applicable)
If Yes, please explain:

Please list other relatives and family friends who are especially important in this child's life:

What do you feel is important for me to know about this child's relationships with siblings, extended family members or special family friends?

PARENT-CHILD RELATIONSHIP:

What are your strengths as a parent?

What are your weaknesses/challenges as a parent?

How do you think the child's other parent would describe their strengths?

How do you think the child's other parent would describe their weaknesses/challenges?

What, if any, major disagreements have you had with this child's other parent regarding child-rearing and parenting.

What has been the most enjoyable time for you with this child?

What has been the most challenging for you with this child?

What do you find the most satisfying about parenting this child?

List three hopes and/or dreams you have for this child:

ADDITIONAL INFORMATION:

Is there anything else you feel we should know about your child? ____

Signature: ____ Date: ______________________________