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Helen G. Jenne, Psy.D., LLC
Psychologist
Board Certified in Clinical Psychology

Child Questionnaire

Patient
Name:_____Date:_____

Street Address:_____City, State:_____

Zip Code:_____Home Phone:_____Work Phone:_____

Cell Phone:_____ Best Number to reach you:_____

Date of Birth:_____Age:_____Sex:_____

Name of Parents:_____Ages:_____

Who Referred child to Dr. Jenne?:_____Phone:_____

Medical History
Please List Any Current (C) and Past (P) Medical
Problems:_____
_____
_____

Date of Last Physical:_____Physician Name & Number_____

History of head injury?_____Date_____

History of loss of consciousness?_____Date_____

Has child ever been exposed to toxic
substances?_____Date_____Type_____

Does child have hearing or vision problems?_____Corrective device_____

What was the date of child's last vision exam_____hearing
exam_____?

Please List Any Current Medications child is now taking:
Name of Drug Dose Times per day Prescribing MD Began
_____
_____

_____
_____
_____
_____

Name other medications child has taken in the past:_____

How many times has child been hospitalized overnight in a medical hospital?_____

Describe reason(s) for above:_____

What medical conditions run in child's biological family?_____

Mental Health History

Approximately how many hours of sleep does child obtain per night?:_____

Does child have difficulty falling asleep, remaining asleep, becoming restless, or having nightmares (please describe):_____

Approximately how many meals does child eat per day?_____

Does child have difficulty with his/her appetite? If so, how?_____

Has child experienced a weight change of 5 lbs. or more per month over the past year?_____

Does child have difficulty with socializing with others? If yes, please describe:_____

Does child/adolescent have alcohol or drug related problems? If yes, please describe:_____

Please circle all of the following that apply to child/adolescent and fill in the number of times of each occurrence:

Service	Number of times
Previous counseling	
Previous psychological evaluation	
Inpatient psychiatric hospitalization	
Partial hospitalization	
Inpatient alcohol treatment	
Alcohol detoxification	
AA meetings	
Inpatient drug treatment	
Drug detoxification	
NA meetings	

Please describe any mental health conditions for which child has been treated and treatment dates:_____

Is child currently under the treatment of a psychiatrist?_____Name/Phone of MD:_____

Please list all family members with mental health or psychological problems:_____

Psychosocial History

Number/Names of other children in home:_____

Describe your relationship with your child_____

Describe your spouse's relationship with your child_____

Describe your child's relationship with his/her siblings_____

Circle the response that best reflects your child:

Region from: Northeast
South
Midwest
West

Country from: USA Other:_____

Raised: Urban
Rural

Religion, if any, in which child was raised:_____Active now?_____

Developmental History

Ethnic background:_____

List any complications with child's birth:_____

List any complications with mother's pregnancy:_____

Did child have any difficulties in developmental areas such as walking, talking, and toilet training?_____

Please list any major childhood illnesses child suffered:_____

Education History

Grade in school:_____

Average grade made during school:_____

Did child ever repeat a grade in school?_____What grade(s)?_____

Was child ever diagnosed with a learning disability in school?_____Area:_____

List subjects that were difficult for child:_____

Has child attend special education classes?_____List:_____

#School detentions:_____#School suspensions_____#School expulsions_____

General History

What are child's leisure time activities?_____

What are child's chores at home?_____

What behaviors concern you at this time?_____
How do you discipline your child?_____

_____
Parent(s) Signature