CONFIDENTIAL

CHILD ASSESSMENT QUESTIONNAIRE

To the best of your ability, please answer all of the questions. All the information that you provide in this questionnaire will remain strictly confidential.

Date: mm / dd / yy

Referral: _____

Person Answering Questions: _____

Relationship to Child: _____

Child Personal Information

Last Name: _____ **First Name:**_____

Sex: ☐ **Male** ☐ **Female** **Birthdate:** mm / dd / yy **Age:** _____

Place of birth: _____ **Citizenship:** _____

Mother tongue: _____ **Other Spoken Languages:** _____

School: _____ **School Tel:** _____

Grade: _____ **Home Room Teacher:** _____

Principal: _____

Parent Relationship

☐ **Married** ☐ **Common Law** ☐ **Separated** ☐ **Divorced**

Parent Information

Mother

Last Name: _____ **First Name:**_____

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Home Tel.: ( ) _____ **Work tel.:** ( ) _____**Ext** ___

Mobile: ( )_____ **E-mail:**_____

Father

Last Name: _____ **First Name:**_____

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Home Tel.: ( ) _____ **Work tel.:** ( ) _____**Ext** ___

Mobile: ( )_____ **E-mail:**_____

Family History

Is this child closer to one parent than the other? NO YES If yes, which?_____

Has this child ever experienced any parental separations, divorces, or death? NO YES

If yes, when? _____ **How old was this child at the time?** _____

Please describe the circumstances. _____

_____

If parents are separated or divorced, who has custody of the child? _____

How often does the other parent see this child? (Check one)

□ Weekly or More Often □ Once or Twice a Month □ Few Times a Year □ Never

What do you enjoy most about this child? _____

_____

What do you find most difficult about raising this child? _____

_____

Presenting Problems

In your opinion, why are you seeking help for this child?

Describe as much detail as possible, including what exactly the problem is, who it involves, when it began, what else was going on in the child's life at that time, how frequently it occurs, what bothers you most about it etc…

What do you expect out of this therapy? What are your goals?

Stresses

List what you think are the Top 3 stresses in your child's life right now.

1. _____

2. _____

3. _____

Symptoms

What symptoms has the child been displaying lately?

Symptom	Yes	No	Comment
Hyperactive behavior	☐	☐	
Lack of Attention	☐	☐	
Memory Lapses (Short-term or Long-term)	☐	☐	
Defiance of Parent /Teacher	☐	☐	
Anger /Tantrums	☐	☐	
Social avoidance	☐	☐	
Aggressive Behavior	☐	☐	
Headaches or Migraines	☐	☐	
Insecurity/Fears of being alone	☐	☐	
Academic Problems	☐	☐	
Fatigue	☐	☐	
Fears/Phobias	☐	☐	

Education and School

Current Grade: _____ Current School: _____

Subject strengths:_____

Subject weaknesses:_____

Behavior at school: _____

_____

_____

Comments from teachers: _____

_____

_____

Has Been Retained a Grade in School **No** **Yes** _____

Has skipped a Grade in School **No** **Yes** _____

Has Difficulty with Reading **No** **Yes** _____

Has Difficulty with Math **No** **Yes** _____

Gets Poor Grades **No** **Yes** _____

Has Been Tested for Special Education **No** **Yes** _____

Dislikes Going to School **No** **Yes** _____

Is Absent from School Frequently **No** **Yes** _____

Do you have any concerns about the quality of this child's school or teachers? **No** **Yes**

If yes, when and why? _____

_____

Family

Please describe your child's relationship with his/her family members. (If applicable)

Name	Age	Rate 1- 10	Quality

Medical History

Condition	Duration	Comments

Medical Symptoms

Please indicate whether this child currently has any of the following problems. If yes, describe how often.

Respiratory

Frequent Colds No Yes _____

Chronic Cough No Yes _____

Asthma No Yes _____

Hay Fever No Yes _____

Sinus Condition No Yes _____

Cardiovascular

Shortness of Breath No Yes _____

Dizziness with Physical Exertion No Yes _____

Activity Limitation No Yes _____

Heart Murmur No Yes _____

Gastrointestinal

Excessive Vomiting No Yes _____

Frequent Diarrhea No Yes _____

Constipation No Yes _____

Stomach Pain No Yes _____

Nausea No Yes _____

Genitourinary

Urination in Pants/Bed No Yes _____

Pain while Urination No Yes _____

Excessive Urination **No** **Yes** _____

Strong odor to Urine **No** **Yes** _____

Musculoskeletal

Muscle Pain **No** **Yes** _____

When? _____ **Where?** _____

Clumsy Walk **No** **Yes** _____

Poor Posture **No** **Yes** _____

Other Muscle Issues **No** **Yes** _____

Poor balance **No** **Yes** _____

Skin

Frequent Rashes **No** **Yes** _____

Bruises Easily **No** **Yes** _____

Sores **No** **Yes If yes, describe.** _____

Severe Acne **No** **Yes** _____

Itchy Skin (Eczema) **No** **Yes** _____

Blushes/turns red **No** **Yes**_____

Vision

Vision Problems **No** **Yes** _____

Wears Glasses

Or Contacts **No** **Yes** _____

Date of Most Recent Vision Exam _____

Neurological

Seizures/Convulsion No Yes If yes, describe. _____

Speech Defects No Yes _____

Accident Prone No Yes _____

Bites Nails No Yes _____

Sucks Thumb No Yes _____

Grinds Teeth No Yes _____

Has Tics/Twitches No Yes _____

Bangs Head No Yes _____

Bowel Movements in Pants/Bed No Yes _____

Has child ever taken tranquilizing medication? No Yes

If yes, when? _____ What medication? _____

Has child ever taken medication for ADD, ADHD, or similar problems? No Yes

If yes, when? _____ What medication? _____

Allergies

Allergy to Medicine No Yes If yes, describe. _____

_____

Allergy to Food No Yes If yes, describe. _____

_____

Other Allergies No Yes If yes, describe. _____

_____

Hearing

Ear infections No Yes _____

Hearing Problems **No** **Yes** _____

Ear Tubes **No** **Yes** _____

Date of Most Recent Hearing Exam _____

Speech

Stuttering **No** **Yes** _____

Unclear Speech **No** **Yes** _____

Other Speech Issues **No** **Yes** _____

Date of Most Recent Speech Exam _____

Sleep

How many hours does he/she sleep per night? _____

What time does he/she usually go to bed? _____

Does he/she have difficulty sleeping? ☐ Yes ☐ No

If so, what is the difficulty:

☐ Falling asleep ☐ Nightmares

☐ Waking up throughout the night ☐ Early Wake Up

☐ No Sleep at all ☐ Bedwetting

☐ Fears Sleeping alone

☐ Other. Specify: _____

Does your child feel or seem rested upon waking? ☐ Yes ☐ No

Medical Care

Child's Physician _____ **Telephone** _____

How often does this child see a doctor? _____ **Date of Last Visit** _____

Is this child currently on medication? **No** **Yes**

If yes, indicate type and reason _____

Is this child presently taking any vitamin or health supplements? **No** **Yes**

If yes, indicate type and reason _____

Psychological History

Has this child ever had psychological counseling or therapy? **No** **Yes**

If yes, therapist's name _____

Date of Last Visit _____ **Telephone** _____

Reason for Consulting at the time _____

Does your family have a psychiatric history? **No** **Yes** _____

Mood State

Using the scale below, where do you see your child right now? (Please circle your response)

1	2	3	4	5	6	7	8	9	10
No Anxiety. Relax and mellow most of the time.								Very Panicky. Highly Anxious.	

Using the scale below, where do you see your child right now? (Please circle your response)

1	2	3	4	5	6	7	8	9	10
Happy Joyful				Sad				Depressed Apathetic	

Has your child ever spoken about committing suicide? ☐ Yes ☐ No

If Yes, please specify.

Diet

Consider what your child would eat on a typical day.

Food	Yes	No	How Many Portions Per Day?
Dairy (i.e. Milk, Yogurt, Cheese, etc…)	☐	☐	
Grains (i.e. Bread, Cereal, etc…)	☐	☐	
Vegetables	☐	☐	
Fruit	☐	☐	
Meat (i.e. Beef, Chicken, Turkey, etc…)	☐	☐	
Meat Alternatives (i.e. Soy based products, tofu, etc…)	☐	☐	
Fish (i.e. Salmon, Tuna, etc…)	☐	☐	
Caffeine (i.e. Chocolate, colas, coffee, tea, energy drinks)	☐	☐	
Candy, energy bars, protein shakes	☐	☐	

Exercise

Does your child exercise regularly? ☐ Yes ☐ No

Type of Exercise	Frequency	Comments

Hobbies/Interests/Activities

List some of your child's favorite hobbies, interests and activities.

Hobby/Interest/Activity	Frequency	Why does he/she enjoy this activity?

Additional Comments

Is there anything else you feel is important to share right now?

Authorization to Release Confidential Information

I understand that the health professionals at Clinique PsySanté use a multi-disciplinary team approach and may share pertinent information regarding my child's case with each other only. The purpose of this is solely to better serve the interests of my child/family. I authorize this sharing amongst the health professionals at PsySanté.

Signature of main custodial parent/legal guardian: _____

Date: _____

I understand that the Psychologist/ Practitioner involved in my child's case may need to communicate with another person(s) involved in my child's care (ex. physician, teacher, principal, coach, etc.).

I authorize myPsychologist/Practitioner, to share pertinent information regarding my child's file specifically to:

1.

Name	Relationship	Address	Phone Number

2.

Name	Relationship	Address	Phone Number

3.

Name	Relationship	Address	Phone Number

4.

Name	Relationship	Address	Phone Number

Signature of main custodial parent/legal guardian: _____

Date: _____