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Child and Adolescent Life History Questionnaire

Instructions:

The purpose of this questionnaire is to obtain a comprehensive picture of your child's circumstances and difficulties. This is a general questionnaire that covers many aspects of psychiatry some may not apply to your child, please state that those are not applicable (N/A). If you do not desire to answer a question merely write "do not care to answer," but please respond to ALL questions. Answering these questions as fully and as accurately as possible will assist in completing your child's evaluation. You are requested to answer these routine questions in your own time instead of using your actual consulting time, especially because you may not remember some of the answers right away. Please return the form to me, in the enclosed envelope, BEFORE your consultation.

It is understandable that you may be concerned about what happens to this information, because much of this is highly personal. Case records are strictly CONFIDENTIAL. No outsider, not even your closest relative or family doctor, is permitted to see this record without your written permission.

If your child has had previous evaluations or treatment, or has been hospitalized, please contact all previous physicians, therapists or hospitals immediately, and send each of them a signed request form asking them to send a copy of your case history to me, before your consultation. (Consent for release of Patient Information forms are included at the back of this packet for this purpose.) This is very IMPORTANT. Doctors and hospitals are often slow to answer such requests. You should call the physician/institution in addition to sending them the enclosed request form.

A. General Information

Date:			
Patient's Last Name:			
Patient's First Name:			Middle Initial:
Home Address:			
Home Tel.:	Cell.:		Ethnicity:
Gender: F M	Age:	Height:	Weight:
Date of Birth:		Place of Birth:	
Do you live in a house, condo, hotel room, apartment, etc.?			
List all people living in the household, their age and relationship to the patient:			
If any siblings are living outside the home please list their name and ages:			
Person filling this form (circle one): Mother Father Stepmother Stepfather			
Primary language spoken at home:			
Other languages spoken at home:			
Referred by:			Telephone:
Address:			
School:			Grade:
Address:			Telephone:
Teacher's name:			
Guidance counselor's name:			
School psychologist's name (if applicable):			

Pediatrician's name:	Telephone:	
Address:		
Mother:		
Name:	Age:	DOB
Address (if different):		
Home/Cell Telephone:	Work Telephone:	
Highest education achieved (year and degree received):		
Occupation:		
Time at present job:	Annual income:	
Religion	Race/ethnicity:	
Please check: ☐Biological parent ☐Adoptive parent ☐Step-parent ☐Adoptive parent		
Father:		
Name:	Age:	DOB
Address (if different):		
Home/Cell Telephone:	Work Telephone:	
Highest education achieved (year and degree received):		
Occupation:		
Time at present job:	Annual income:	
Religion	Race/ethnicity:	
Please check: Biological parent Adoptive parent Step-parent Adoptive parent		
Step-parent:		
Name:	Age:	DOB
Address (if different):		
Home/Cell Telephone:	Work Telephone:	
Highest education achieved (year and degree received):		
Occupation:		
Time at present job:	Annual income:	
Religion	Race/ethnicity:	

Date of marriage:	Are parents living together?
If not, are parents: ☐ Separated ☐ Divorced ☐ Deceased ☐ Never married	
Please provide date of separation/divorce/decease:	
How old was the child when parent's separation/divorce/deceased:	
Legal Guardian(s):	
Is the other parent in agreement with this evaluation? ☐ Yes ☐ No	

Please describe in your own words what are the child's current difficulties:
How long has this problem been of concern to you?
Whose idea was it that this child gets evaluated?

Strengths and Interests:

What do you most enjoy about your child?

What are her/his strengths and abilities? (e.g.: athletics, academics, hobbies, social skills)

What are the child's favorite activities?

Have there been or are there currently any major changes or stresses in the child's family?

☐ Yes ☐ No

If yes, please mark all that apply: (Please indicate any stress in the last six months as current)

Current	Past	
		1. Financial problems
		2. Frequent moves
		3. Job changes
		4. Drinking/drug problems
		5. Arguments between parents
		6. Separation or divorce of parents
		7. Remarriage of parents
		8. Separation from sibling(s)
		9. Separation from other family member
		10. Separation from significant non-family members
		11. Physical confrontations between parents
		12. Frequent physical punishment
		13. Mental illness in family
		14. Physical illness in family
		15. Psychiatric hospitalization of a parent
		16. Death in the family
		17. Sexual promiscuity or incestuous behavior in the family
		18. Legal problems
		19. Other family problems

Please describe:

Siblings: (If any are deceased please give your age at the time of death and cause of death).

Name	Age	Gender	Marital Status	Occupation / observations

Relationship with siblings:

Past:
Present:

Was this child ever separated from one or both parents for more than one week during before the age of 5? ☐No ☐Yes

How about later in childhood or adolescence (other than vacations) for more than a month? ☐No ☐Yes

If you answered yes in any of these questions please describe fully and give your child's age on the back of this page.

Was this child brought up entirely by parents, if not who brought him/her up, and between what years?
In what ways was/is this child disciplined?
Give an impression of your home atmosphere:
Is this child able to confide in his/her parents?

B. Developmental History

a. Prenatal

Was the child adopted?	☐ Yes	☐ No
If yes at what age? _____		

If your child was adopted please complete the rest of the prenatal history from the information you have.

Length of pregnancy? _____ months		
Was it a multiple birth?	☐ Yes	☐ No
Birth weight: _____ pounds _____ ounces. Birth Length: _____inches		
Apgar Scores: one minute _____ five minutes _____		
Was the child a "Blue Baby"?	☐ Yes	☐ No

During pregnancy, did you have any of the following: (Check all that are appropriate)

☐ Spotting or vaginal bleeding
☐ Emotional problems
☐ Anemia
☐ Elevated blood pressure
☐ Threatened miscarriage/early contractions
☐ Diabetes swollen ankles
☐ Kidney disease
☐ Accidents or injury
☐ Heart disease
☐ Convulsions/seizures
☐ Thyroid problem
☐ High fevers
☐ German measles
☐ Hormones
☐ Toxemia
☐ Rh/other blood incompatibilities
☐ Alcohol use
☐ Cigarette smoking
☐ Drug abuse. Please specify: _____
☐ Medication/s. Please specify _____
☐ Chronic illness(es). Please specify: _____
☐ Other difficulties. Please specify: _____

Length of Labor: _____ hours

Was delivery unusual in any way? (e.g. was the cord wrapped around the neck, etc?)

☐ Yes ☐ No If yes, please describe: _____

Was it a breech delivery? ☐ Yes ☐ No

Did you have a Caesarean section? ☐ Yes ☐ No

Was labor induced? ☐ Yes ☐ No

If induced, was it planned? ☐ Yes ☐ No

Were you given any medication/anesthesia? ☐ Yes ☐ No

If yes, what kind? _____

Were forceps utilized? ☐ Yes ☐ No

In the first few days after birth, did the baby have or require any of the following?

☐ Yellow skin (jaundice) ☐ Other medical problems

☐ Breathing problems ☐ Blood transfusions

☐ Convulsions ☐ Incubator time

☐ Special nursing care ☐ Oxygen

☐ Heart problems ☐ Infections

How long after birth did the baby leave the hospital? _____

Did the baby leave with the mother? ☐ Yes ☐ No

b. Infancy:

Please check if there were difficulties in any of the following:

☐Sucking ☐Sleeping ☐Swallowing ☐Crying

Did you feed by breast? ☐ Yes ☐ No How long? _____months

Did the baby have any difficulty with breast feeding? ☐ Yes ☐ No

If you feed by bottle, what type of formula did you use? _____

Was it difficult to find a formula that the baby tolerated? ☐ Yes ☐ No

Was body contact pleasurable for the baby? ☐ Yes ☐ No

Was the baby overly sensitive to sound? ☐ Yes ☐ No

Was the baby colicky? ☐ Yes ☐ No

Was the baby “limp or stiff”? ☐ Yes ☐ No

Baby’s activity level? ☐ High ☐ Low ☐ Average

c. Early developmental skills

Motor development	**Early**	**Nrml**	**Late**	**Age attained**
Held head up				
Sat without help				
Crawled				
Stood				
"Cruised"				
Ran				
Rode a tricycle				
Tied shoes				
Fed self				
Dress self				
Toileting				
Stayed dry – day				
Stayed dry – night				
Bowel control				
Languages				
Spoke first word				
Named objects				
Used 2-3 words together				
Spoke in complete sentences				

Has your child lost any abilities or skills he or she previously had? ☐ Yes ☐ No

If yes, which one/s: _____

C. Educational History

Age at which your child began school: _____

Was the family ever advised to delay entering the child into kindergarten because of immaturity? ☐ Yes ☐ No

If yes, please specify: _____

Were there any problems with the child's entry into school? (e.g.: fear of leaving parents, feigned illness, etc.) ☐ Yes ☐ No

If yes, please specify: _____

Please check next to any educational problem that your child currently exhibits

☐ Has difficulty with reading

☐ Has difficulty with arithmetic

☐ Has difficulty with spelling

☐ Has difficulty with writing

☐ Has difficulty with other subjects. Please specify: _____

☐ Does not like school

a. Preschool

Did your child attend preschool? ☐ Yes ☐ No

Were any problems with learning noted? ☐ Yes ☐ No

Were any problems with behavior or social interactions noted? ☐ Yes ☐ No

b. Elementary/High school

Has this child ever repeated a grade? ☐ Yes ☐ No

If yes, which one/s: _____

Has this child ever received special education services? ☐ Yes ☐ No

If yes, please describe: _____

Does this child dislikes/resists going to school? ☐ Yes ☐ No

If yes, Please describe: _____

Did your child cut classes? ☐ Yes ☐ No

If yes, Please describe: _____

Was your child able to form close relationships with peers? ☐ Yes ☐ No

If no, Please describe: _____

Has your child been able to keep these relationships? ☐ Yes ☐ No

If no, Please describe: _____

Has your child ever been bullied or given nicknames? ☐ Yes ☐ No

If yes, Please describe: _____

Please describe your child's social adjustment with peers, e.g., many friends, few close friends, shy, odd, outgoing, etc.

Kindergarten:
Elementary school:
Middle school:
High school:

Please list all schools your child attended, including preschool programs

School	City, State	Grade(s) attended

a. Has your child ever received evaluations in the following areas:

	Date	Provider
Speech-language evaluation		
Occupational therapy evaluation		
Physical therapy evaluation		
Educational evaluation		
Psychological evaluation		
Developmental evaluation		
Neurological evaluation		
Genetics evaluation		
Developmental evaluation		
Ophthalmological (vision) evaluation		
Audiological (hearing) evaluation		

b. Has your child ever participated in the following treatments?

	Date	Provider
Speech-language therapy		
Occupational therapy		
Physical therapy		
Psychotherapy		
Psychiatric/medication therapy		
Vision training		
Please bring copies of evaluation reports and treatment summaries (if available)		

D. Psychiatric History

a. Please list and give complete information about whom you have consulted previously

Name and Profession	Type of treatment (medication, psychotherapy, both)	Dates of treatment (initial consultation, frequency, termination, ongoing)	Reason for termination (if applicable)

b. Please list and give complete information about psychiatric hospitalizations if any:

Hospital and doctor's name	Dates and/or length of hospitalization	Reason for hospitalization

c. Please list and give complete information about previously and currently used psychiatric medications including over-the-counter and herbal preparations. Start with medications you are currently using. (Please see list on last page for help with names, continue on the back of this page if more space is needed)

Medication	Dates taken (From and to/current)	Highest dosage taken	Results (positive or negative)	Side effects	Reason for discontinuation

d. Has your child ever treated with electroconvulsive therapy (ECT), transcraneal magnetic stimulation (TMS) and/or vagal nerve stimulation (VNS)

☐ Yes ☐ No

e. Has your child ever had any ideas of suicide? ☐ Yes ☐ No

Has your child ever attempted suicide? ☐ Yes ☐ No

If so, how many times? _____

Please explain on the back of this page what led you to consider suicide, what was your attempt and if you were hospitalized after the attempt. Please describe each attempt.

f. Has your child ever cut/burned or mutilated him/herself? ☐ Yes ☐ No

Please explain on the back of this page what led/leads your child to do this, frequency, outcome of these behaviors (stitches, hospitalization, day-treatment, etc.) Please describe each event if possible or describe the most severe ones.

g. Has your child ever been violent? ☐ Yes ☐ No

Please explain on the back of this page what led your child to violence, what did she/he do and explain what the consequences were including police involvement. Please describe each episode.

h. Has your child ever used/abused substances? ☐ Yes ☐ No

If yes, please describe use of alcohol, caffeine, tobacco and/or drugs (i.e. : marijuana, cocaine, heroin, ecstasy, PCP, GHB, amphetamines, etc.) *–next page-*

Substance	Age at first use	Last use	Ever in treatment for this substance	Currently using?
			☐Yes ☐No	☐Yes ☐No
			☐Yes ☐No	☐Yes ☐No
			☐Yes ☐No	☐Yes ☐No
			☐Yes ☐No	☐Yes ☐No

Did this child ever go through detoxification and/or rehabilitation for any of these substances? ☐Yes ☐No

E. Recreational / Work history

Personality traits of your child
☐ Withdrawn ☐ Anxious ☐ Outgoing ☐ Aggressive ☐ Clingy ☐ Other _____

Does your child belong to any groups or organizations? ☐ Yes ☐ No
If yes, Please describe: _____

Please list any jobs or chores your child has:
At home: _____

Outside of home: _____

Paid employment: _____

F. Family History

a. Medical family history

Has any member of your child's family (parents, siblings, grandparents, children, significant other, etc.) ever had any medical problems (for example diabetes, high blood pressure, epilepsy, seizures, high cholesterol, stroke, heart problems, etc.) Also include history in parents and/or siblings of genetic disorders (e.g.: Turner's, Tay-Sachs, Sickle cell, etc.)

List family member	Describe problem	Describe treatment of hospitalization for this problem

b. Psychiatric family history

Has any member of your family (parents, siblings, grandparents, children, significant other, etc.) ever had any psychiatric problems whether diagnosed or suspected (for example anxiety, phobias, depression, manic depressive illness, schizophrenia, etc.) Also include history in parents and/or siblings of hyperactivity (as a child), academic difficulties, speech problems, kept back in school, etc.

List family member	Describe problem	Describe treatment of hospitalization for this problem

c. Substance abuse family history

Has any member of your family (parents, siblings, grandparents, children, significant other, etc.) ever had any problems with drugs or alcohol?

List family member	Describe problem	Describe treatment of hospitalization for this problem

G. Medical History

a. Allergies

Does your child have any allergies to medication? ☐ No ☐ Yes – please describe	
Medication name	Reaction
Does she/he have any other allergies to food/insects/etc.? ☐ No ☐ Yes – please describe	
Allergy type	Reaction

b. Medical illnesses or health problems

Describe illness or health problem	Age at time diagnosed
List any surgeries/operations your child had	Age at time
List any accidents your child had	Age at time

c. Non-psychiatric medications including oral contraceptives
Please include all medications that you can recall your child taking currently and in the past:

Medication name and dosage	Dates taken (From and to/ currently taking)	Reason that medication was prescribed	Results (positive or negative)	Reason for discontinuation

H. **Sexual Maturation History**

Did you notice any unusual behavior in your child (e.g.: cross-dressing, excessive or public masturbation, sexual offenses, promiscuity, etc.)? ☐ Yes ☐ No

If yes, please describe: _____

Does your child appear comfortable with the opposite sex? ☐ Yes ☐ No

If no, please describe: _____

What is your child's sexual orientation?

☐ heterosexual ☐ gay ☐ lesbian ☐ bisexual ☐ transexual

At what age did your child show adult body development? _____

Is your child sexually active? ☐ Yes ☐ No

Does he/she practice safe sex? ☐ Yes ☐ No ☐ Not applicable

Menstrual/pregnancy history ☐ Not applicable

Age at first period:
Are periods regular? ☐ Yes ☐ No
Duration
Are they heavy? ☐ Yes ☐ No
Do periods affect her moods? ☐ Yes ☐ No
Does she experience (check all that apply) ☐ Irritability ☐ Anxiety ☐ Depression
Date of last period

Please list all pregnancies your child has had in chronological order and give complete information requested below. If more space is needed, continue on the back of this page.

Year	Number of months pregnancy lasted	Describe illnesses or complications during pregnancy or delivery	Outcome
1.			☐ miscarriage ☐ elective abortion ☐ living child
2.			☐ miscarriage ☐ elective abortion ☐ living child

Addendum

List of psychotropic medications

Adapin (Doxepin)
Alprazolam
Amantadine
Amitriptyline
Amoxapine
Anafranil (Clomipramine)
Antabuse (Disulfiram)
Artane (Trihexyphenidyl)
Asendin (Amoxapine)
Ativan (Lorazepam)
Aventyl (Nortriptyline)
Benadryl (Diphenhydramine)
Benztropine
Bupropion
Buspar (Buspirone)
Buspirone
Calan (Verapamil)
Calcium Carbimide
Carbamazepine
Carbolith (Lithium)
Celexa (Citalopram)
Chlordiazepoxide
Chlorpromazine
Cibalith-S (Lithium)
Citalopram
Clomipramine
Clonazepam
Clopixol (Zuclopenthixol)
Clozapine
Clozaril (Clozapine)
Cogentin (Benztropine)
Cylert (Pemoline)
Dalmane (Flurazepam)
Depakene (Valproate)
Depakote (Divalproex)
Desipramine
Desyrel (Trazodone)
Dexedrine (Dextroamphetamine)
Dextroamphetamine
Diazapam
Dilantin (Phenytoin)
Divalproex
Diphenhydramine
Disulfiram
Doxepin
Duralith (Lithium)
Edronax (Reboxetine)
Effexor (Venlafaxine)
Elavil (Amitriptyline)
Endep (Amitriptyline)
Epitol (Carbamazepine)
Epival (Divalproex)
Eskalith (Lithium)
Ethosuximide
Etrafon (Perphenazine)
Fluanxol (Flupenthixol)
Fluoxetine
Flupenthixol
Fluphenazine
Flurazepam
Fluvoxamine
Halcion (Triazolam)
Haldol (Haloperidol)
Haloperidol
Imipramine
Imovane (Zopiclone)
Inderal (Propranolol)
Isoptin (Verapamil)
Janimine (Imipramine)
Klonopin (Clonazepam)
Lamotrigine
Lamictal (Lamotrigine)
Largactil (Chlorpromazine)
Libritabs (Chlordiazepoxide)
Librium (Chlordiazepoxide)
Lithane (Lithium)
Lithium
Lithizine (Lithium)
Lithobid (Lithium)
Lithonate (Lithium)
Lithotabs (Lithium)
Lorazepam
Loxapac (Loxapine)
Loxapine
Loxitane (Loxapine)
Ludiomil (Maprotiline)
Luvox (Fluvoxamine)
Manerix (Moclobemide)
Maprotiline
Mellaril (Thioridazine)
Mesoridazine
Methylphenidate
Moclobemide
Modecate (Fluphenazine)
Mysoline (Primidone)
Nardil (Phenelzine)
Navane
Nefazodone
Norpramine (Desipramine)
Nortriptyline
Nozinan
Olanzapine
Orap
Oxazepam
Pamelor (Nortriptyline)
Parnate (Tranylcypromine)
Paroxetine
Paxil (Paroxetine)
Pemoline
Permitil (Fluphenazine)
Perphenazine
Pertofrane (Desipramine)
Phenelzine
Piportil (Pipotiazine)
Pipotiazine
Primidone
Prolixin (Fluphenazine)
Propranolol
Protriptyline
Prozac (Fluoxetine)
Quetiapine
Reboxetine (Edronax)
Restoril (Temazepam)
Rhotrimine (Trimipramine)
Risperidal (Risperidone)
Risperidone
Ritalin (Methylphenidate)
Rivotril (Clonazepam)
Sabril (Vigabatrin)
Serax (Oxazepam)
Serentil (Mesoridazine)
Seroquel (Quetiapine)
Sertraline
Serzone (Nefazodone)
Sinequan (Doxepin)
Stelazine (Trifluoperazine)
Sulpiride
Surmontil (Trimipramine)
Symmetrel (Amantadine)
T-Quil (Diazapam)
Tegretol (Carbamazepine)
Temazepam
Temposil (Calcium Carbimide)
Thioridazine
Thiothixene
Thorazine (Chlorpromazine)
Tofranil (Imipramine)
Trazodone
Triazolam
Trifluoperazine
Trihexyphenidyl
Trilafon (Perphenazine)
Trimipramine
Triptil (Protriptyline)
Valium (Diazapam)
Valium Injection (Diazapam)
Valproate
Valproic acid
Valrelease (Valproate)
Venlafaxine
Verapamil
Vivactil (Protriptyline)
Vigabatrin (Sabril)
Wellbutrin (Bupropion)
Xanax (Alprazolam)
Zarontin (Ethosuximide)
Zoloft (Sertraline)
Zopiclone
Zuclopenthixol
Clopixol (Zuclopenthixol)
Zyprexa (Olanzapine)