Haydon-Davis Counseling, Inc.
Wendy Haydon Davis, LCSW
Licensed Clinical Social Worker

305 Kingsley Lake Drive Suite 702
St. Augustine, FL 32092
Telephone: (904) 716-5619
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LIFE HISTORY QUESTIONNAIRE

Child/Adolescent

The purpose of this questionnaire is to obtain an understanding of your life experience and background. Then we can begin to develop a comprehensive treatment program suited to your specific needs. Please return this questionnaire when completed, or at your scheduled appointment.

Name: ______________________________ Circle: M / F Date: ______________

Birth Date: ______________ Age: ________ Place of Birth: ______________________

By who were you referred? ____

Chief Complaint:

____

____

____

Presenting Problem: (check all that apply)

______Very unhappy
______Irritable
______Temper Outbursts
______Withdrawn
______Daydreaming
______Fearful
______Clumsy
______Overactive
______Slow
______Short attention span
______Distractible
______Lacks initiative
______Undependable
______Peer conflict
______Phobic

______Impulsive
______Stubborn
______Disobedient
______Infantile
______Mean to others
______Destructive
______Trouble with the law
______Running away
______Self-mutilating
______Head banging
______Shy
______Rocking
______Strange behavior
______Strange thoughts

______Fire setting
______Stealing
______Lying
______Sexual trouble
______School performance
______Truancy
______Bed wetting
______Soiled pants
______Eating problems
______Sleeping problems
______Drug use
______Sickly
______Alcohol use
______Suicide talk

Explain: ____

____

How long have these problems occurred? (number of weeks, months, years)? ______________

What made you seek help at this time? ___________________________________

Any previous mental health contact? Please explain.

____

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Pt Name:________________

Problems perceived to be: _______very serious ________serious ________not serious

What changes would you like to see in your child/self?

____

What changes would you like to see in your family?

____

PSYCHOSOCIAL HISTORY

Mother-Relationship to child: _________Natural parent ___________Relative
_________Step-parent ___________Adoptive parent

Occupation: ____Education:_________________________________

Religion: ______________________ Birthplace:__________________________ Birth date:____________________

Father-Relationship to child _________Natural parent ___________Relative
_________Step-parent ___________Adoptive parent

Occupation:____Education:_________________________________

Religion:______________________ Birthplace:_______________________ Birth date:________________________

Marital History of Parents: Natural Parents: _____married when________
_____separated when________
_____divorced when________
_____deceased when________
Step-Parents _____married when________

Pt's religious/spiritual upbringing? ____

If child is adopted: Adoption source ____

LIVING ARRANGEMENTS: Number of moves in child's life:_____
Places Dates
____
____
____
____

Was the child ever placed, boarded, or lived away from the family? ____Yes ____No

Explain: ____

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Pt Name:_________________

What are the major family stressors at the present time, if any? ____

____

BROTHERS and SISTERS: (indicate if step-brothers and sisters)

Name _______ _______ _Age Sex Any Mental Health or substance abuse problems

1.____
2.____
3.____
4.____
5.____

List all extended family members by their relation to the patient who have drug and/or alcohol problems (legal or illegal), history of depression, self-destructive behavior, or legal problems.

____

____

Others living in the home (and their relationship):

____

Are there any family members with chronic or severe medical problems? If yes, please indicate relative and illness.

____

____

CHILD HEALTH INFORMATION:

	AGE		AGE		AGE
____ High fevers	_____	____ Dental Problem	_____	_____ Unconsciousness	_____
____ Pneumonia	_____	____ Weight Problems	_____	_____ Stomach Problems	_____
____ Flu	_____	____ Allergies	_____	_____ Concussions	_____
____ Encephalitis	_____	____ Skin Problems	_____	_____ Accident Prone	_____
____ Meningitis	_____	____ Asthma	_____	_____ Anemia	_____
____ Convulsions	_____	____ Headaches	_____	_____ Head Injury	_____
____ Fainting	_____	____ Blood Pressure	_____	_____ Dizziness	_____
_____Sinus Problems	_____	____ Tonsils Out	_____	____ Heart Problems	_____
____ Visions Prob.	_____	____ Hyperactivity	_____	_____Hearing Prob.	_____
_____Earaches	_____	_____Other Illnesses, etc.	_____	(Explain) ________________________	

Has the child ever been hospitalized? ____ No ____ If yes, at what age and for what reason?

____

Has the child ever taken, or is he/she taking presently any prescribed medications? If yes, please explain.

____

____

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Pt Name:_________________

Allergies- please list:____

Primary Care Physician or Pediatrician:______________________________Phone: ________________________

DEVELOPMENTAL HISTORY: _____ Child wanted? Yes / No Planned for: Yes / No

Normal Pregnancy: ___ Yes ___ If No- Please Explain ____

BIRTH: Were there any complications during birth? ____No If yes, please explain.__________________________

____

Did mother use or abuse alcohol or drugs during pregnancy? _____ No _____ Yes – What? ___________________

NEWBORN PERIOD: Please circle any of the below issues you had with your child.

irritability vomiting difficulty breathing difficulty sleeping convulsions/twitching colic

DEVELOPMENTAL MILESTONES: Met at appropriate ages: ______yes ________no

If no, explain: ____

EARLY SOCIAL DEVELOPMENT:

Relationship to siblings and peers: ______ individual play _______ group play ______ competitive
_______ cooperative ______ leadership role _______ a follower

Describe special habits, fears, or idiosyncrasies of the child:

____

EDUCATIONAL HISTORY:

What school does your child attend and what grade? ____

Types of classes: ______ regular _____ learning disability _____ emotionally handicapped

Did child skip a grade? ___No ___ If yes, grade______ Repeat grade? ___ No ____If yes, grade _______

Does child attend school on a regular basis? ___ Yes ___ No Does child appear motivated for school? Yes / No

Has child ever been suspended or expelled? ___ No ___ If yes, for what?

____

Any school issues I should be aware of, but not mentioned?

____

Highest grade on last report card?___________________ Lowest grade on last report card?___________________

Favorite subject?________________________________ Least favorite subject?__________________________

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Pt Name:_________________

ACADEMIC PERFORMANCE:

Does child participate in extracurricular activities? _______Yes _____ No (Explain)

____

In school, how many friends does child have: _____a lot _____ a few ____none

What are child's educational aspirations? ___ quit school ___ graduate high school ___ go to college

List child's special interests, hobbies, skills:

____

____

Has the child ever been involved with the legal system? ____ No ____ Yes (if yes, explain)

____

Has child every used any drugs or alcohol? If yes, please indicate type and whether use is past or present.

____

____

Has child ever been employed? _____ No _____ Yes - Explain

____

ADDITIONAL COMMENTS: ____

____

____

____

____

Signature of parent of guardian **Date**

____ _______________________

Signature of client if age 14 or older **Date**