Therapeutic Services Agency Incorporated Since 1978

THERAPEUTIC SERVICES AGENCY, INC.

220 Railroad St. SE • Pine City, MN 55063 • (320) 629-7600 • Depot Fax (320) 629-7900 • Hilltop Fax (320) 629-0003

CHILD MEDICAL/SOCIAL HISTORY QUESTIONNAIRE

Child's Name: _____ Birth Date: _____

Your Name: _____ Today's Date: _____

In your own words, what are you hoping will be accomplished by our seeing your child?

_____

_____

_____

Has this child had a previous mental health treatment or evaluation? ☐Yes ☐No

If so, where and when? _____

For what purpose? _____

_____

Biological Father's Name: _____ Age: _____

Biological Mother's Name:_____ Age: _____

Parents' Current Marital Status: ☐ Married ☐ Separated ☐ Divorced

Who has legal custody of the child? _____

Has your child ever lived with someone other than you? ☐Yes ☐No

Has the child ever experienced verbal, physical or sexual abuse or neglect? ☐Yes ☐No

If yes, what is your child's comfort level with discussing this abuse? ☐Good ☐Fair ☐Poor

Your Child's Physician's Clinic: _____ Phone: _____

Clinic Address: _____
(City) (State)

MEDICAL HISTORY

Does your child have a history of:

	No	Yes		No	Yes
Hospitalization	____	____	Allergies	____	____
Head Injury	____	____	Asthma	____	____
Seizure	____	____	Vision Problems	____	____
Poisoned	____	____	Hearing Problems	____	____
Many Ear Infections	____	____	Speech Problems	____	____
Poor Coordination	____	____	Difficulty Walking	____	____
Sleep Problems	____	____	History/Current:		
Eating Problems	____	____	Bed Wetting	____	____
			Bed Soiling	____	____

Circle the speed at which you think your child has developed, overall: SLOW NORMAL RAPID

Is there any specific area of concern, ex. potty training, speaking, walking, peer relations? _____

_____

Medications your child is currently taking:

Medication	Strength	Directions

EDUCATIONAL HISTORY

Current School: _____

Current Grade: _____ School District: _____

To the best of your knowledge, at what grade level is your child functioning in:

Reading?: _____ Spelling?: _____ Arithmetic?: _____

Does your child have trouble with handwriting? ☐Yes ☐No

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

If yes, which grade(s): _____

What grades does your child typically receive? _____

Has your child ever had an IEP or 504 Plan? ☐Yes ☐No

What, if any, special educational services does your child receive? _____

_____

Has your child had special testing in school over the past year or two? ☐Yes ☐No Grade _____

Please provide copy of report if possible.

Please check **Yes** or **No** to the following, as they apply:

	Yes		No
Teacher complaints about behavior	☐		☐
Attendance problems	☐		☐
Difficulties finishing/turning in homework	☐		☐
Suspension/Expulsion	☐		☐
Fighting/Confrontational Behavior	☐		☐
Relating to/playing with other children	☐		☐
Involved in sports, youth groups or clubs	☐		☐
Is your child employed?	☐		☐

If employed, where and how many hours a week?

FOR TODAY'S VISIT

What are your primary concerns regarding your child?

_____

_____

_____

_____

How serious do you think your child's difficulties are at this time? (Please circle)

No Problem Minor Problem Moderate Problem Serious Problem

What do you like about your child? _____

_____

Listed below are items about children's behavior. Decide how much concern you have about each area **over the last few months**. Mark your choice by placing an X in the appropriate column to the right of each item.

BEHAVIORAL AREA	NO PROBLEM		SOME PROBLEM		LARGE PROBLEM
Eating Problems	☐		☐		☐
Sleeping Problems	☐		☐		☐
Fears or Worries	☐		☐		☐
Speech Problems	☐		☐		☐
Wets or Soils Self	☐		☐		☐
Clingy, Dependent	☐		☐		☐
Temper Tantrums	☐		☐		☐
Many Physical Complaints	☐		☐		☐
Clumsy or Poor Coordination	☐		☐		☐
Socially Immature	☐		☐		☐
Nervous Twitches or Tics	☐		☐		☐
Unhappy Child	☐		☐		☐
Angry Child	☐		☐		☐
Brags	☐		☐		☐
Shyness	☐		☐		☐
Problems With Friends	☐		☐		☐
Alcohol/Drug Use	☐		☐		☐
Fights With Siblings	☐		☐		☐
Acts Without Thinking	☐		☐		☐
Overactive	☐		☐		☐
Short Attention Span	☐		☐		☐
Stealing	☐		☐		☐
Lying	☐		☐		☐
Perfectionistic	☐		☐		☐
Not Doing What is Asked	☐		☐		☐
Argues	☐		☐		☐
Whines/Cries	☐		☐		☐
Suicidal Talk or Thoughts	☐		☐		☐
Likes Being Alone	☐		☐		☐
Overweight	☐		☐		☐
Lacks Energy	☐		☐		☐
Strange Ideas	☐		☐		☐
Strange Behaviors	☐		☐		☐
Sexualized Behaviors	☐		☐		☐
Other (Please Specify):					
1.	☐		☐		☐
2.	☐		☐		☐
3.	☐		☐		☐
4.	☐		☐		☐
5.	☐		☐		☐
6.	☐		☐		☐
7.	☐		☐		☐
8.	☐		☐		☐

FAMILY MENTAL HEALTH/MEDICAL HISTORY

We are interested in whether anyone in your family, other than this child, has or has had any of the conditions listed. Please put an X in the column of the family member(s) who have or have had each problem.

Conditions:	**Child's Mother**	**Child's Father**	**Child's Brother(s)**	**Child's Sister(s)**	**Child's Grandfather(s)**	**Child's Grandmother(s)**	**Other: (Please Specify)**
Hyperactive as a child	☐	☐	☐	☐	☐	☐	☐
Repeated a grade in school	☐	☐	☐	☐	☐	☐	☐
Speech Problems	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐
Mental Retardation	☐	☐	☐	☐	☐	☐	☐
Behavioral Problems in Childhood	☐	☐	☐	☐	☐	☐	☐
Trouble with the Law	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Eating Problems	☐	☐	☐	☐	☐	☐	☐
Anxiety Problems	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐
Other Emotional Problems	☐	☐	☐	☐	☐	☐	☐
Drinking Problems	☐	☐	☐	☐	☐	☐	☐
Drug Problem	☐	☐	☐	☐	☐	☐	☐
Serious Health Problems	☐	☐	☐	☐	☐	☐	☐
Other Serious Problems (please specify)	☐	☐	☐	☐	☐	☐	☐

_____ _____

Your Signature Date