Children's Resource Group / CRG
9106 N. Meridian St., Suite 100
Indianapolis, IN 4626
TEL: (317) 575-9111 FAX: (317) 571-4470

Child/Adolescent Questionnaire

Child/Adolescent's Legal Name	Birth Date:	Today's Date:
Preferred Name/Nickname:	Child/Adolescent's Race:	Preferred Pronouns:
Current Gender Identity:	Sex Assigned at Birth/Legal Sex:	Sexual Orientation:
Current School Attending:	Current Grade Placement:	Child's Religious/Cultural Affiliation:
Person Completing Questionnaire:	Relationship to Patient:	Who referred you here?

HOW DID YOU HEAR ABOUT CRG?

- ☐ Family Dr. (Dr.'s name: _____)
- ☐ Therapist (Therapist's name: _____)
- ☐ School (School name: _____)
- ☐ Family member (Name: _____)
- ☐ Friend / Coworker (Name: _____)
- ☐ CRG Website
- ☐ Other (_____)

PURPOSE OF EVALUATION

What are your questions or concerns regarding your child/adolescent?

When did you first become concerned about your child/adolescent?

FAMILY OF ORIGIN INFORMATION

Legal Guardian /Parent#1 Name: _____ Relationship:_____

Partner/Stepparent Name (if not parent #2)_____

Legal Guardian/Parent #2 Name: _____ Relationship:_____

Partner/Stepparent Name (if not parent #1)_____

Is child/adolescent biologically related to both parents? Yes/no Comments:

Please list the Name and Relationship of additional individuals that will be involved in your child's care:

_____

_____

Individuals other than custodial parents will require a completed release of information to be involved in communication, billing, and treatment regarding the patient.

Parents are: Date

Married	◯	_____
Single	◯	_____
Partnered	◯	_____
Separated	◯	_____
Divorced	◯	_____
Widowed	◯	_____

* Please describe any current legal custody/visitation arrangements and provide a copy of the custody decree or court order:

Is your child/adolescent a foster child?_____ Yes _____ No Length of time in your home _____

Is your child/adolescent adopted? _____ Yes _____ No Age at adoption _____

If a foster child or adopted, has this been discussed with your child/adolescent?_____ Yes _____ No

Who has legal guardianship of the child/adolescent?

Who provides primary care to the child/adolescent when parent(s) are at work?

Please **list <u>all</u> persons** presently living in your home:

Name	Sex	Age	Relation to Child	Present or Highest Grade Completed	Occupation

Please list immediate family members **not** living in your home:

Name	Sex	Age	Relation to Child	Present or Highest Grade Completed	Occupation

Has your family experienced any of the following difficulties?

	Yes	No	**Please explain**
Death of a family member	◯	◯	
Serious illness	◯	◯	
Marital problems	◯	◯	
Unemployment/Financial Trouble	◯	◯	
Abuse (sexual, verbal, physical, and or emotional)	◯	◯	
Neglect/Abandonment	◯	◯	
Other significant events/losses/changes	◯	◯	
Significant changes due to the 2020 Coronavirus Pandemic	◯	◯	

FAMILY HISTORY

Please list family history for blood relatives for any of the following:

	None	Yes	Relation to Child	Comments
Seizure disorders				
Learning difficulties				
ADHD/ADD				
Depression				
Suicide attempts (please explain)				
Bipolar Disorder				
Tic disorders				
Anxiety difficulties				
Schizophrenia/Psychosis				
Substance use/Alcoholism/Illegal prescriptions				
Autism Spectrum Disorder				
Eating Disorders/Obesity				
Other Severe Mental Health				
Other medical diagnoses				

Please list your child's current medical providers, mental health providers or other therapists?

_____

_____

_____

_____

_____

PREGNANCY AND BIRTH HISTORY

Number of living children _____

Number of deceased children _____

This child was the product of pregnancy number _____

DEVELOPMENTAL HISTORY

	Yes	No	Comments
Did gestational parent have any **health problems during pregnancy** with this child? If yes, please describe the problem and the time it occurred during the pregnancy (such as infections, high blood pressure, diabetes, bleeding, weight loss, accidents, fever, etc.)			
Did gestational parent **take any medication, smoke, drink, or use drugs during this pregnancy**? If yes, please list.			
Did gestational parent **carry the child less/more than nine months**? If yes, please indicate the length of pregnancy.			
Were there any **difficulties with delivery**? If yes, please describe the problems (such as Cesarean section, slow heart rate, fever, etc.)			
How much did your baby **weigh at birth**?	_____ pounds, _____ ounces		
Did your baby **need any special care** during the first few hours/days after delivery? If yes, please describe.			
Did gestational parent have any **difficulty caring for the child** during the first few months of life? If yes, please describe or mark N/A			

	Yes	No	Comments
Was your child's **development any faster or slower** than that of other children? **Please explain**.			
At what age did your child **sit alone**?			
At what age did your child **crawl**?			
At what age did your child **walk alone**?			
At what age did your child **say single words**?			
At what age did your child **combine words**?			
Is your child **toilet trained**? If yes, age what age?			
Does your child have **toileting accidents during the day**? If yes, how often?			

Please describe your child/adolescent during infancy and/or preschool years.

Sleeping and eating habits:

Separation anxiety:

Self-soothing activities:

Temperament:

Sensitivities to noise, touch, and/or taste:

PAST MEDICAL ILLNESSES

	Yes	No	Comments
Has your child/adolescent **ever been hospitalized**? If yes, please describe, including **child's age**.			
Has your child/adolescent ever had any **serious accidents** requiring medical care? If yes, please describe, including your child's age. (Include broken bones.)			
Has your child/adolescent had or currently have any **serious or chronic illnesses**? Please describe.			
Has your child/adolescent ever had a **seizure or convulsion**? If yes, please describe, including child's age.			
Has your child/adolescent ever had **tics**? (Facial movements, eye-blinking, etc.)			
Does your child/adolescent have any known **allergies**? Please describe.			
Do you feel your child/adolescent has **trouble hearing**? If yes, please explain.			

	Yes	No	Comments
Do you feel your child/adolescent has **trouble seeing**? If yes, please explain.			
Are you concerned about your child/adolescent's **eating habits**? If yes, please describe.			
Are you concerned about your child/adolescent's **sleep habits**? If yes, please describe; include trouble falling asleep, not being able to sleep in own room, nightmares, awakenings, snoring, and trouble waking up.			
Does your child/adolescent have **headaches** more than once a week?			
Is your child/adolescent presently taking **any medication**? If yes, please **list the medications, dosages**, **by whom it was prescribed and why**. *If taking more than three medications, please list additional medications in the space provided below.			**Medication 1** Name: Dose: Prescribed by: Reason: **Medication 2** Name: Dose: Prescribed by: Reason: **Medication 3** Name: Dose: Prescribed by: Reason:

Please list any additional medications here:

Does your child/adolescent have any **previous diagnoses**? ____ Yes ____ No
*If so, please use the space below to **list each diagnosis, date of diagnosis, and the provider who made each diagnosis**.

EDUCATIONAL HISTORY

Please list your child's schools:

Name Grade Levels

Preschool/Daycare: _____

_____

Kindergarten: _____

_____

Elementary: _____

_____

Middle School: _____

_____

High School: _____

_____

LEARNING AND PSYCHOLOGICAL/MEDICAL INTERVENTIONS

Has your child/adolescent **received treatment or been evaluated** for any of the following?

	Yes	No	Dates	Where and/or Who
Educational/Psychological testing				
Speech/language therapy				
Physical therapy				
Occupational therapy				
Tutoring				
Counseling/Psychotherapy				
Psychiatry				
Restrictive Diet/Supplements				
Other (please list)				

Has your child/adolescent ever been **retained or held back** a grade? ____ Yes ____ No

Does your child/adolescent receive **special education services (IEP) or have a 504 Plan**? *If so, please attach a copy of the most current IEP/504. ____ Yes ____ No

Please list your child/adolescent's most **current grades/GPA**: _____

Reading ____ History/ Social Studies ____ Writing ____
Spelling ____ Math ____ Science____

Please list any **additional classes and current grades** below.

Name of **elementary school age** child's current primary teacher_____

Please describe your child's **study habits**:

Have you noticed any **changes in academic performance** recently?

SOCIAL HISTORY

How does your child/adolescent **entertain themself**? Please list **hobbies or activities** they enjoy:

Describe your child/adolescents' **interactions with family members**:

Describe your child/adolescents' **interactions with peers**:

Please describe your child/adolescent's present **peer group**:

Please list **extracurricular activities** which your child/adolescent has participated in during the last six months:

Have you noticed any **changes in your child/adolescent's emotions or behaviors? Please explain.**

Please describe what you consider to be your child/adolescent's **strengths**:

Do you have concerns regarding possible **alcohol and/or drug use**? _____ Yes_____ No _____N/A

CHILD/ADOLESCENT'S BEHAVIOR

Please indicate any of the following behaviors that you observe with your child/adolescent; please describe any areas of concern:

Vanderbilt Parent Rating Scale

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	○	○	○	○
2. Has difficulty staying focused on what needs to be done	○	○	○	○
3. Does not seem to listen when spoken to directly	○	○	○	○
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	○	○	○	○
5. Has difficulty organizing tasks and activities	○	○	○	○
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	○	○	○	○
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	○	○	○	○
8. Is easily distracted by noises or other stimuli	○	○	○	○

Symptoms	Never	Occasionally	Often	Very Often
9. Is forgetful in daily activities	○	○	○	○
10. Fidgets with hands or feet or squirms in seat	○	○	○	○
11. Leaves seat when remaining seated is expected	○	○	○	○
12. Runs about or climbs too much when remaining seated is expected	○	○	○	○
13. Has difficulty playing or beginning quiet play activities	○	○	○	○
14. Is "on the go" or often acts as if "driven by a motor"	○	○	○	○
15. Talks too much	○	○	○	○
16. Blurts out answers before questions have been completed.	○	○	○	○
17. Has difficulty waiting his/her turn.	○	○	○	○
18. Interrupts or intrudes in on others' conversations and/or activities	○	○	○	○
19. Argues with adults	○	○	○	○
20. Loses temper	○	○	○	○
21. Actively defies or refuses to go along with adults' requests or rules	○	○	○	○
22. Deliberately annoys people	○	○	○	○
23. Blames others for his or her mistakes or misbehaviors	○	○	○	○
24. Is touchy or easily annoyed by others	○	○	○	○
25. Is angry or resentful	○	○	○	○
26. Is spiteful and vindictive (wants to get even)	○	○	○	○
27. Bullies, threatens or intimidates others	○	○	○	○
28. Starts physical fights	○	○	○	○
29. Lies to get out of trouble or to avoid obligations (i.e., "cons" others)	○	○	○	○
30. Skips school without permission	○	○	○	○
31. Is physically cruel to people	○	○	○	○
32. Has stolen things that have value	○	○	○	○
33. Deliberately destroys others' property	○	○	○	○
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	○	○	○	○
35. Is physically cruel to animals	○	○	○	○
36. Has deliberately set fires to cause damage	○	○	○	○
37. Has broken into someone else's home, business, or car	○	○	○	○
38. Has stayed out at night without permission	○	○	○	○
39. Has run away from home overnight	○	○	○	○
40. Has forced someone into sexual activity	○	○	○	○
41. Is fearful, anxious, or worried	○	○	○	○
42. Is afraid to try new things for fear of making mistakes	○	○	○	○
43. Feels worthless or inferior	○	○	○	○
44. Blames self for problems, feels guilty	○	○	○	○
45. Feels lonely, unwanted, or unloved; complains that "no one loves him/her"	○	○	○	○

Symptoms	Never	Occasionally	Often	Very Often
46. Is sad, unhappy, or depressed	○	○	○	○
47. Is self-conscious or easily embarrassed	○	○	○	○
Additional Items:				
48. Has done cutting and/or self-injurious behaviors	○	○	○	○
49. Has made suicide attempts	○	○	○	○

Thank you for completing this form.