Transpire Life Counseling, LLC
Child Questionnaire
(Parents please complete for children under 14 years of age)

Patient Name: _____Age_____ DOB: _____ Date: _____

Telephone no: (Home) _____ (Work) _____ (Cell) _____
__
Legal Guardian Name: _____Relationship to Patient: _____

Emergency Contact Information: Name: _____

Relationship_____ Telephone No: _____

Home Phone #: _____Work Phone #: _____

Please state in your own words why you have come to today:
_____
_____
_____
_____

History of Present Illness: (*How long has this particular issue been going on*):
_____
_____
_____
_____

Sleep Disturbance Yes □ No □ (if yes please describe)
_____
_____
_____

Appetite Changes Yes □ No □ (if yes please describe)
_____
_____
_____
_____

Psychiatric History:

I have received treatment for: Substance abuse □ Mental health issues □ Both □

The treatment occurred at:

□ Other private psychiatrist □ Mental Health Center
□ Hospital □ Other counseling service □ Other facility

If hospitalized, please list dates and where hospitalized_____
_____
_____

Are you presently being treated? Yes □ No □ If yes, by whom? _____

Are you currently being prescribed psychiatric medications? Yes □ No □

If Yes, please list **Current Psychiatric** medications_____
_____

Psychological Testing:

Have you ever had psychological testing done in the past? □ Yes □ No

If yes, When_____ and by Whom_____

Medical History:

Name of your primary care doctor _____

Phone: _____ Date last seen: _____

Do you have a history of any medical problem? Yes □ No □ If so, what? _____
_____

Are you presently being treated for any medical problem? Yes □ No □ If so, what?
_____
_____

Please list any current **Non-Psychiatric Medications**_____

_____

Have you ever been treated for a nutritional problem?	□ Yes	□ No
Do you make yourself sick because you feel uncomfortably full?	□ Yes	□ No
Do you worry you have lost control over how much you eat?	□ Yes	□ No
Have you recently lost more than 14 pounds in a 3-month period?	□ Yes	□ No
Do you believe yourself to be fat when others say you are too thin?	□ Yes	□ No
Would you say that food dominates your life?	□ Yes	□ No

Are you experiencing any physical pain? Yes ___ No ___

Family Psychiatric/Medical History: *(*Please list any familial psychiatric or major medical problems)
_____
_____
_____

Social History*:* (Who does child live with, please state if parents are divorced and share custody also list any friends or outside supports)
_____
_____
_____

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Developmental History*:*

Your child's weight at birth: _____lbs. _____oz. Was this a full-term birth? Yes □No □
If no, explain:
_____
_____

Did either parent use drugs or alcohol at the time of conception? Yes □ No □

Were there any complications with the labor & delivery such as jaundice, infection etc.? Yes □ No □
If yes, explain:
_____
_____

Did child meet all developmental milestones on time? Yes □ No □
If No please explain _____
_____
_____

Educational/Occupational

Most Recent Grade Completed: _____

Name school currently attending _____

Recent Report Card Grades _____

IEP/504 Yes □ No □ (if yes please explain why) _____
_____
_____

Behavioral Problems:
Has child ever had in or out of school suspension? Yes □ No □ (if yes please explain why)
_____
_____
_____

Has child ever had problems with bullying? Yes □ No □ (if yes please explain)
_____
_____
_____

Military Dependent: Yes □ No □

Spiritual/Religious Affiliation

Attends church Yes □ No □ If Yes where _____

History of Legal Problems No □Yes □ (if yes please explain:)

_____
_____
_____

History of trauma*? (**To include abuse, domestic violence, witnessing of; and military trauma**)*:

No □ Yes □ (**If yes please explain**):

_____
_____
_____

Thank you for your cooperation and patience. Our clinician will see you shortly and discuss these and other issues in greater detail and help you develop a treatment plan to effectively deal with these issues.