Inner Balance Counseling LLC

Child History Questionnaire

Child's name:
Child's address:
Relationship to child:

What are your concerns about your child? (Please include any behaviors/symptoms you've noticed. For example: feeling down/depressed, anxious/worried, outbursts, anger, few friends, can't focus, etc.)
How long have these issues been a concern? How severe is it now? Has it always been that severe? How often do you see the problem?

How much conflict between parent/caregiver and child?	☐None	☐Mild	☐Moderate	☐Severe
How often do parents agree on how to raise the kids?	☐N/A	☐Always	☐Usually	☐Inconsistently	☐Rarely
How is parental supervision of the child?	☐Good	☐Adequate	☐Difficult	☐Inconsistent	☐Absent
Does a parent have any mental health needs that may be impacting the child? Please explain.				
Does a parent have any physical health needs that may be impacting the child? Please explain.				
How often do parent(s) spend fun/positive time with child?	☐Frequent	☐Occasional	☐Infrequent	☐N/A
How satisfied are parent(s) with the parent-child relationship(s)?	☐Satisfied	☐Neutral	☐Dissatisfied	☐Wants Child Removed

Any comments or further information about parent/child relationship(s)?

Child's close/immediate Family Members (including siblings and anyone who lives in the home):

Name:	Relation:	Age:	Lives w/ child?
1.			☐
2.			☐
3.			☐
4.			☐
5.			☐
6.			☐
7.			☐
8.			☐

Does child have any siblings (circle)? ☐Yes ☐ No

How much conflict between sibling(s) and child:	☐None	☐Mild	☐Moderate	☐Severe	☐N/A
How often child and sibling(s) do fun/positive activities together:	☐Frequent	☐Occasional	☐Infrequent	☐N/A	
Any comments or further information about child/sibling(s) relationships?					

Who has legal custody of the child? Who has physical custody of the child? Are there any other legal or custody issues? ☐Yes ☐No If yes, please explain:			
Child lives with:	☐Biological parent	☐Adoptive or foster	☐ Relative
If other caregiver, please explain:			
Does child live in more than one household? ☐Yes ☐No If yes, please explain:			
Primary language spoken at home?			
Child lives in: ☐Apt-Rent ☐House-Rent ☐House-Own ☐Foster ☐Shelter ☐Group ☐Residential ☐Homeless			
☐Friend's house	☐Relative/caregiver's house	☐Other (explain):	
Housing is:	☐Stable	☐Relatively Stable	☐Unstable ☐Risk of Homelessness
Have there been frequent changes in housing? ☐Yes ☐ No Please list number/frequency of moves, general locations:			

Biological Parents' Marital Status:	☐Never married ☐Married ☐Separated	☐Divorced ☐Mother Remarried	☐Father Remarried ☐Unknown	☐Parent declines to answer ☐Other

Name of Parent/Caregiver	Relationship	Age	Education Level	Full-Time/Part-Time/No Job

Mother's Family History (include child's mother, aunts, uncles, grandparents)

Any family history of physical health problems? ☐Yes ☐ No	If yes, please explain who, what
Any family history of mental health problems? ☐Yes ☐No	If yes, please explain who, what
Any family history of trauma (violence, neglect, abuse, etc.)? ☐Yes ☐No	If yes, please explain who, who, what
Any family history of chemical health problems (drugs, alcohol)? ☐Yes ☐No	If yes, please explain who, what
Any family history of educational problems? ☐Yes ☐ No	If yes, please explain who, what
Any family history of legal problems (incarceration, etc.)? ☐Yes ☐No	If yes, please explain who, what:
Any family history of serious financial problems (basic needs not met, etc.)? ☐Yes ☐ No	If yes, please explain
Any family history of other stressors you'd like to share? ☐Yes ☐No	If yes, please explain

Father's Family History (include child's father, aunts, uncles, grandparents)

Any family history of physical health problems? ☐Yes ☐ No	If yes, please explain who, what:
Any family history of mental health problems? ☐Yes ☐ No	If yes, please explain who, what:
Any family history of trauma (violence, neglect, abuse, etc.)? ☐Yes ☐No	If yes, please explain who, what:
Any family history of chemical health problems (drugs, alcohol)? ☐Yes ☐No	If yes, please explain who, what:
Any family history of educational problems? ☐Yes ☐No	If yes, please explain who, what:
Any family history of legal problems (incarceration, etc.)? ☐Yes ☐No	If yes, please explain who, what:
Any family history of serious financial problems (basic needs not met, etc.)? ☐Yes ☐ No	If yes, please explain:
Any family history of other stressors you'd like to share? ☐Yes ☐ No	If yes, please explain:

How/Is the family involved in the community? Please explain. (Church, volunteer, community centers, etc.)					
What are your family's strengths? Who/what helps you get through difficult times?					
Are basic needs met? (food, shelter, clothing, medical care) ☐ Yes ☐ No					
Child/Family's religious affiliation?	☐ Decline to Discuss	☐ No particular spiritual/religious beliefs	☐ Do have particular spiritual/religious beliefs		
Is religion/spirituality a source of strength for the child/family? ☐Yes ☐ No					
Child/Family's frequency of attending religious services/activities:	☐None/Never	☐Couple times a year	☐Holidays	☐Monthly	☐Weekly
Are there any impacts religion may have on the child? (positive or negative): ☐Yes ☐No					

Where was child born?	Where were parents born?
Race:	Ethnicity:
Primary language spoken at home:	Native language:
Socio-Economic Status (low-income, middle-class, upper-middle class, etc.):	
Did parents come from another country? (Country, year):	

Do parents and child have any difficulties due to immigration/differences in culture? ☐Yes ☐No ☐N/A
How do you feel about mental health and seeking mental health services?
Are there any culturally specific healing practices you/your family uses?
Are there any of your child's behaviors or symptoms you think might be related to cultural concerns? ☐Yes ☐No

Child's Social Functioning

What are the child's peer/social relationships like?
What, if any, community activities does client engage in (church, community center, clubs, etc.)?
What are the child's hobbies/interests?

Neighborhood Safety Concerns	☐No ☐Yes	Comments:
Safety Concerns that your child is Vulnerable	☐No ☐ Yes	
Safety Concerns that your child is Aggressive	☐No ☐Yes	
Sexual Acting Out Behavior	☐No ☐Yes	
Sexual or Gender Identity Concerns	☐No ☐Yes	
Has a Girlfriend/ Boyfriend	☐No ☐Yes	
Sexual Behavior History	☐ No ☐ Yes	
Community Activities	☐ No ☐ Yes	
Community Functioning Concerns	☐ No ☐ Yes	
Peer Relationship Concerns	☐ No ☐ Yes	
Delinquent Behavior	☐ No ☐ Yes	
Exposure to gangs	☐ No ☐ Yes	
History of Fire Setting/Fire Play	☐ No ☐ Yes	
History of Running Away from the Home	☐No ☐Yes	
History of Being Bullied	☐ No ☐ Yes	

History of Bullying Others	☐ No ☐ Yes	
Any Other Concerns?	☐ Yes ☐ No	

What are the child's strengths? What is good about them? How do they get through hard times?
What does the child struggle with? What do they need to work on?

Developmental History

☐**History is known, provided below**	☐**Do not know any of this info.**	☐**I know some of the information below**

When mother was PREGNANT with child (check all that apply):

☐Had regular prenatal care	☐Had to use medication(s)	☐Used drugs/alcohol	☐Used nicotine
☐Physical health issues present	☐Major illness/injury during pregnancy	☐Other complications	
Please explain any complications/concerns (if information is unknown, please note that below):			

When mother gave BIRTH to child (check all that apply):

☐Premature	☐Early	☐On Time	☐Over 2 weeks late
☐Vaginal birth	☐Planned C-Section	☐Emergency C-Section	
Weight and Length):	Other complication(s):		
Please explain any birth concerns (if information unknown, please note below):			

When child was an INFANT (check all that apply):

☐Infant was easy to soothe	☐Concerns about failure to thrive	☐Was alert to surroundings/people	
☐Had stiffness/rigidity	☐Infant enjoyed being held	☐Cried excessively, was irritable	☐Difficulties with eating
☐Problems with bonding/attachment with caregiver	☐Sleeping difficulties	☐Postpartum concerns with mother	
☐Separated from primary caregiver for extended period of time	Other:		
Please explain any infancy concerns (if information unknown, please note below):			

Developmental MILESTONES:

Receptive communication (understanding language)	☐Early	☐On Time	☐ Delayed	☐ Unknown
Expressive communication (using language/speaking)	☐Early	☐ On Time	☐ Delayed	☐ Unknown
Dressing	☐Early	☐ On Time	☐ Delayed	☐ Unknown
Fine Motor skills	☐Early	☐ On Time	☐ Delayed	☐ Unknown
Gross Motor skills	☐Early	☐ On Time	☐ Delayed	☐ Unknown
Toileting	☐Early	☐ On Time	☐ Delayed	☐ Unknown
Crawling	☐Early	☐ On Time	☐ Delayed	☐ Unknown
Walking	☐Early	☐ On Time	☐ Delayed	☐ Unknown
First Words	☐Early	☐ On Time	☐ Delayed	☐ Unknown
Feeding	☐Early	☐ On Time	☐ Delayed	☐ Unknown
Cognitive	☐Early	☐ On Time	☐ Delayed	☐ Unknown

Childhood/ Early Adolescent Development (check if item applies or has applied to child)

☐Difficulty separating from parent(s)	☐Temper Tantrums	☐Calm	☐Outgoing	☐Easily distracted
☐Destructive	☐Inconsolable	☐Enjoy being held	☐Extreme mood changes	☐Did not like to be touched
☐Afraid of new places	☐Unresponsive to discipline	☐Self-harm behavior	☐Prefers toys over people	
☐Alert to environment	☐Other:			
Please explain concerns/observations:				

Has child ever lived in any of the following places (circle)?

☐Correctional facility	☐Detention facility	☐Emergency shelter	☐Foster family
☐ Group home	☐Homeless shelter	☐Relative's home	☐ N/A
If any above checked, please explain:			

Medical/Physical Health History:

Child's overall physical health:	☐ Excellent	☐ Good	☐ Poor
Please list/explain any ongoing health concerns:			
Are Immunizations up to date:	☐ Yes	☐ No	☐ Unknown

Health History			Comments
Allergies to Medicine	☐ No	☐ Yes	
Allergies to Food	☐ No	☐ Yes	
Seasonal Allergies	☐ No	☐ Yes	
Surgeries	☐ No	☐ Yes	
Head Injury	☐ No	☐ Yes	
Ear Infections	☐ No	☐ Yes	
Infectious Diseases	☐ No	☐ Yes	
Serious Illnesses	☐ No	☐ Yes	
Major Accidents	☐ No	☐ Yes	
Hospitalizations	☐ No	☐ Yes	
Lead Exposure	☐ No	☐ Yes	
Seizures	☐ No	☐ Yes	

Tics	☐ No	☐ Yes	
Asthma	☐ No	☐ Yes	
Vision Problems	☐ No	☐ Yes	
Hearing Problems	☐ No	☐Yes	
Speech Problems	☐No	☐Yes	
Developmental Delays	☐No	☐Yes	

Check if any of the following are a concern:

☐Excessive weight loss/gain ☐ Eating difficulties ☐ Stomach aches	☐ Nightmares ☐ Sleep Difficulties ☐ Soiling Accidents	☐ Day-Time Wetting ☐ Sensory Difficulties	☐ Other medical concerns ☐ N/A- None of these

If checked, please explain:

Medications

Current prescription or herbal medications: ☐ No ☐ Yes
If yes, include name of medication, dosage, frequency, response to medication, prescribing physician:

Are the medications being taken as prescribed? ☐ No ☐ Yes

Does the child/family feel the medications are helpful? ☐ No ☐ Yes

Current cultural healing Practices: ☐ Yes ☐ No
If Yes, please explain:

Past prescription or herbal medications: ☐ Yes ☐ No
If yes, please list:

Primary Care Information

Does client have a Primary Care Provider (PCP)? ☐ No ☐ Yes
If yes, name of provider:

Date of last Physical Exam:	☐ Unknown	☐ Over 1 year	☐ 6-12 months	☐ 0-5 months

Dental Information

Does client have dental provider? ☐ No ☐ Yes

Date of last dental exam	☐ Unknown	☐ Over 1 year	☐ 6-12 months	☐ 0-5 months

Mental Health Treatment History:

Child has had (check all that apply):	☐ Assessments	☐ Individual therapy	☐ Family therapy
☐ In Home therapy	☐ Skills Training	☐ Mental Health Case Management	☐ Medication Management
☐ Day Treatment	☐ Partial Hospitalization	☐ Inpatient	☐ Residential
☐ Residential substance abuse facility	☐ Other		

Current mental health diagnosis:

Please list past providers, and estimated dates of mental health services:

Please check all items that child has experienced/witnessed:

☐ Domestic violence/abuse	☐ Physical abuse	☐ Verbal abuse	☐ Emotional abuse/manipulation
☐ Sexual abuse/molestation	☐ Community violence	☐ Child Protection involvement	☐ Significant loss
☐ Frequent moves	☐ Frequent changes in caregiver	☐ Death of parent	☐ Prolonged separation from parent
☐ Parental divorce or separation	☐ Serious accident or injury	☐ Other highly stressful or traumatic experience(s)	
Please provide details about each checked item (approximate dates/age of child, incident, etc.):			
☐ None of the above apply			

Please checked programs child was in as a child or is in currently:

☐ Head Start	☐ Early Childhood Family Education	☐ Preschool	☐ Daycare	☐ Early Childhood Special Education
Any concerns while attending:				

General Academic Concerns		Comments:
Grades	☐ No Concerns	
	☐ Concerns	
Attendance Problems/Truancy	☐ No Concerns	
	☐ Concerns	
Previous Grade Retentions	☐ No Concerns	
	☐ Concerns	
Suspensions/ Expulsions	☐ No Concerns	
	☐ Concerns	
Academic Problems	☐ No Concerns	
	☐ Concerns	
Behavior Problems	☐ No Concerns	
	☐ Concerns	
Barriers to Learning	☐ No Concerns	
	☐ Concerns	
Changes Schools Repeatedly	☐ No Concerns	
	☐ Concerns	
Other Academic/ School Concerns	☐ No Concerns	
	☐ Concerns	
Academic Strengths and/or concerns:		

Name of School/Grade:

Child's Chemical Health History:

Are you concerned or do you know about any nicotine/tobacco use? Please explain: ☐ Yes ☐ No
Are you concerned or do you know about any alcohol/drug use? Please explain: ☐ Yes ☐ No
Are you concerned or do you know about any prescription drug use? Please explain: ☐ Yes ☐ No

Legal history of child

☐None	☐On probation	☐Awaiting charges	☐Court-Ordered treatment	☐Previous Arrest

Risk History:

Concerns about the child's safety: 1. Self-harm thoughts/actions: ☐ Yes ☐ No 2. Suicidal thoughts/actions: ☐ Yes ☐ No 3. Homicidal thoughts/actions: ☐ Yes ☐ No 4. Access to guns: ☐ Yes ☐ No		If so, please explain:		
Check current concerns:	☐Feels hopeless	☐Destroys property	☐Takes excessive risks	☐Low safety awareness
☐Cannot communicate needs		☐Unpredictable behavior	☐Aggressive behaviors	☐Runs away/flees area
☐Uses weapons	☐Has access to weapons	☐Harms animals	☐Sets fires	☐Uses chemicals (drugs, alcohol)

Would you like me to share information with your child's:

PRIMARY PHYSICIAN: YES ◯ NO ◯

SCHOOL: YES ◯ NO ◯

OTHER (ie: family member, psychiatrist, case manager)): YES ◯ NO ◯

If so, a release of information must be signed. Please request one during our appointment.

Any other information you would like to share?

THANK YOU FOR ALL YOUR TIME ☺