Crawford Consulting and Mental Health Services, Inc
CHILD PSYCHOSOCIAL QUESTIONNAIRE

CCMHS wishes to provide you with the best services possible. In order to do so we need to obtain the following information. This information will be used to assign you to the most appropriate program or therapist. Thank you for your assistance.

Unless otherwise noted, all questions should be answered regarding the person who will be receiving services (for example: your child). If more space is needed, continue responses on back of page.

Name of person to receive services: _____

Date of Birth: _____ Sex: _____ Social Security #: _____

Other names used: _____

Who referred you to treatment? ☐ Self ☐ Dept. Children & Families ☐ Parents ☐ Family member

☐ Physician ☐ School ☐ Work ☐ Other, specify: _____

Who has Legal Custody of Child? _____

Name(s) and relationship(s) of persons providing assessment information:

_____

Are you willing and able to participate in client services when appropriate? **Yes No**

Comments: _____

PRESENTING PROBLEM

Describe specifically the mental, emotional, and/or behavioral problems the Child is currently experiencing. Include frequency, duration:

_____

_____

History of presenting problems (Describe age and circumstances when problematic situation began):

_____

_____

PAST MENTAL HEALTH TREATMENT

Has the Child ever been in the hospital for mental health treatment? **Yes No**
Has the Child ever been in outpatient care for mental health treatment? **Yes No**
Has the Child ever been in an in-school treatment program? **Yes No**
Has the Child ever been in a residential treatment center? **Yes No**

Name of Facility	**Location**	**Reason for Treatment**	**Start/End Dates**	**How did you do?**

Was treatment completed? **Yes No**
Did Child have a positive experience in previous treatment? **Yes No**
Was Child compliant with treatment recommendations? **Yes No**

Comments regarding treatment history: _____

EDUCATIONAL / DAYCARE HISTORY

Current school: _____ Current Grade: _____
Current daycare: _____

History of:
Academic Problems: **Yes** **No** Academic Strengths: **Yes** **No**
If yes, explain: _____
Has Child been retained? **Yes** **No**
If yes, explain: _____
Behavior Problems: **Yes** **No**
If yes, explain: _____
Educational Evaluations: **Yes** **No**
If yes, explain: _____
Special Education Placement: **Yes** **No**
If yes, explain: _____

EMPLOYMENT HISTORY

Has the Child had any Vocational training? **Yes** **No**
Describe: _____
Has the Child had any Vocational problems? **Yes** **No**
Describe: _____
Has the Child ever worked? **Yes** **No**
Describe: _____

SOCIAL RESOURCES

Is the Child able to form and maintain relationships (friendships)? **Yes** **No**
Peer relationships: _____
_____
What are the Child's favorite activities: _____
_____
Hobbies and interests: _____
_____

Girl or Boyfriend: **Yes** **No**

Current problems with close relationships? **Yes** **No**
Describe: _____
Sexually active: **Yes** **No**
Describe: _____
Gang involvement: **Yes** **No**
Describe: _____

LEGAL HISTORY OF CHILD/ADOLESCENT

If history of legal issues, please explain:
_____

Arrest charges pending: **Yes** **No**
Describe: _____
Previous arrests: **Yes** **No**
Describe: _____
Probation: **Yes** **No**
Describe: _____
Court supervision: **Yes** **No**
Describe: _____
Family court/status offenses: **Yes** **No**
Describe: _____
Restitution: **Yes** **No**
Describe: _____

DEVELOPMENTAL HISTORY

Were there complications with the pregnancy? **Yes** **No**
Describe: _____

Did mother sustain any major injury/illness while pregnant? **Yes** **No**
Describe: _____

Did mother use tobacco, alcohol, street drugs or prescription drugs during pregnancy? **Yes** **No**
Describe: _____

Was the delivery premature or overdue? **Yes** **No**
Describe: _____

Were the complications with the labor/delivery? **Yes** **No**
Describe: _____

DEVELOPMENT

Gross motor development: Early Average Delayed Don't Know
Fine motor development: Early Average Delayed Don't Know
Cognitive development: Early Average Delayed Don't Know
Expressive communication: Early Average Delayed Don't Know
Receptive communication: Early Average Delayed Don't Know
Self-care (e.g., dressing, feeding, toileting):
Early Average Delayed Don't Know
Social skills: Early Average Delayed Don't Know
Comments: _____

INFANT TEMPERAMENT

Easy to comfort: **Yes** **No**
Quiet / aloof: **Yes** **No**
Excessive Irritability: **Yes** **No**
Overactive: **Yes** **No**
Describe early sleeping and feeding habits:_____

MEDICAL HISTORY

What is Child's general health: **Excellent** **Good** **Fair** **Poor**
Describe: _____

Immunization Record Current? **Yes** **No**
Any significant illnesses or injuries? **Yes** **No**

Describe:_____
_____

Any neuropsychological (brain) issues? **Yes** **No**

Explain any other medical issues; identify if issues are current or in the past:
_____
_____

TRAUMATIC EVENTS

Current or past experience of being abused or neglected? **Yes** **No**
List: _____

Describe the above, or any other traumatic experience:
_____
_____

MEDICATIONS

Has Child taken any medications for any reason? **Yes** **No**
Was Child compliant with medications in the past? **Yes** **No**

Medication History:

Medications Taken (List All):

Name	Dosage	Reason Prescribed and Date	Reason Ended and Date

List any other medication not included above:
_____

SUBSTANCE ABUSE HISTORY

Does the Child have a history of substance abuse? **Yes** **No**
Describe: _____

Drugs or Alcohol Used (by preference, with #1 being most preferred):

Drug?	How Taken?	Age Started?	Frequency of use?	Most Recent Use?
1.				
2.				
3.				

Does the Child currently live with a person using substances? **Yes** **No**
Has the Child been exposed to substance abuse? **Yes** **No**
Does the Child use tobacco products? **Yes** **No**
Describe: _____

OTHER ADDICTIONS (Pornography, video games, internet, gambling, etc.)? **Yes** **No**
Describe: _____

PSYCHOSOCIAL HISTORY

Are there family issues that need to be addressed in treatment? **Yes** **No**
Does the child have a positive relationship with parents? **Yes** **No**
Does the child have a positive relationship with siblings? **Yes** **No**

Current and past history: Include current living situation, relevant history, and information about family of origin. May include cultural, religious, income, housing information, other agencies involved, and family relationships.

_____
_____

Are there any cultural issues that could interfere with treatment? **Yes** **No**
Describe: _____

CURRENT LIVING SITUATION
Child is in need of food, clothing, or shelter? **Yes** **No**
Describe: _____

Current living arrangement: _____
Number of persons, other than the Child, currently living in the home? _____

HOUSEHOLD MEMBERS

Name?	**Relationship?**	**Date of Birth?**	**Address?**	**Phone?**
1.				
2.				
3.				
4.				

Living environment (condition of the home): **Good** **In need of repair** **N/A**

How many times has the Child's residence changed within the last two years? _____
Explain: _____
_____

How would you rate the family's Socioeconomic Position:
__Upper Class __Upper Middle __Middle Class __Lower Middle Class __Lower Class

Do you possibly qualify for public assistance? **Yes No Unknown**

What are the Child's current support systems:_____

CHILD'S STRENGTHS
List: _____

PAST SIGNIFICANT EVENTS (Check any of the following that apply):
__Significant medical condition of parent/caregiver
__Medical condition of child
__Post-partum adjustment problems of mother
__Mental illness of parent/caregiver
__Substance abuse of parent/caregiver
__Separation/divorce of parent/caregiver
__Adoption
__Abandonment of significant adult caregiver
__Death of parent/caregiver
__Mental retardation of parent/caregiver
__Incarceration of parent/caregiver
Comments: _____

Has the Child ever lived in any of the following settings? **Yes** **No**

__Relative's home	__Foster family	__Orphanage
__Group home	__Therapeutic foster care	__Halfway house
__Emergency shelter	__Correctional facility	__Residential substance abuse facility
__Detention facility	__Homeless	__Hospital
__Other	__Residential treatment center	

Comments: _____

Most restrictive living situation in last 3 months: _____

SPIRITUAL CONSIDERATIONS
Primary religious affiliation: _____

Does Child have spiritual strengths? **Yes** **No**
Does Child have spiritual problems? **Yes** **No**
Describe: _____

Have any **family members** had a history of Mental Illness: **Yes** **No**
If so, describe illness (give diagnosis if known): _____
_____
History of Substance Abuse? _____
_____
History of Criminal Activity? _____
_____
History of Violent Behavior? _____
_____
History of Medical Problems? _____
_____