Nashville Child and Family Wellness Center
Adolescent Initial Visit Questionnaire

Understanding as much as possible about your child is key to the success of your child's treatment. Please answer these questions as honestly as you can, and feel free to explain or add any other information. If a question does not apply to your child or your situation, please write N/A. ***This information, like ALL information you provide, is confidential and will be reviewed only by the provider you are scheduled to see or those for whom you give consent to review this.***

Provider your child is scheduled to see: _____

Child's Name: _____Today's Date: _____

Age: _____ Date of Birth: _____ Sex: ☐ Female ☐ Male

Home Address:

Street: _____

City: _____ State:_____ Zip: _____

PARENT/GUARDIAN INFORMATION

PARENT INFORMATION - Mother:

Mother's Name: _____ Date of Birth:_____

☐ Check here if deceased and please provide date: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Mother's Address: (same as child? ☐ Yes ☐ No)

Street:_____

City: _____ State:_____ Zip:_____

Relationship status:

☐ single ☐ dating ☐ married ☐ remarried ☐ partnered ☐ divorced ☐ separated ☐ widowed

If married, remarried, partnered, divorced or separated, please provide date (s): _____

Employer: _____ Occupation: _____

Highest Level of Education: _____

Religious affiliation if any: _____

PARENT INFORMATION - Father:

Father's Name: _____ Date of Birth:_____

☐ Check here if deceased and please provide date: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Father's Address: (same as child? ☐ Yes ☐ No)

Street:_____

City: _____ State:_____ Zip:_____

Relationship status:

☐ single ☐ dating ☐ married ☐ remarried ☐ partnered ☐ divorced ☐ separated ☐ widowed

If married, remarried, partnered, divorced or separated, please provide date (s): _____

Employer: _____ Occupation: _____

Highest Level of Education: _____

Religious affiliation if any: _____

PARENT INFORMATION – STEP PARENT(S):

Are any step parents involved in your child's life? ☐ No ☐ Yes If yes:

If applicable, what is Stepmother's name, age, and level of involvement in child's life?

_____

If applicable, what is Stepfather's name, age, and level of involvement in child's life?

_____

LEGAL CUSTODY FOR MINORS

If your child is still a minor, please indicate who has legal custody: _____

_____

EMERGENCY AND OTHER CONTACT INFORMATION

Emergency Contact Name: _____ Relationship to child: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

FAMILY INFORMATION

Please list the people in your child's primary home (include all individuals living with your child):

Name	Relationship	Age & DOB	Sex (M/F)	Quality of Relationship

Language(s) spoken in home if not only English: _____

EDUCATIONAL HISTORY:

Schools Attended (list all from Kindergarten to current)

School Name	Grades Attended	Reason for Leaving School

Check the type of classes and/or school your child currently attends (check all that apply):

☐ Regular Education Class ☐ Alternative School ☐ Home School

☐ Emotional/Behavioral Disorder Class ☐ Special Education Classes (specify type: _____)

☐ Other (describe: _____)

Does your child have any learning difficulties, disabilities or special needs? ☐ No ☐ Yes

If yes, please describe: _____

_____

Does your child have an IEP? ☐ No ☐ Yes If yes, describe: _____

Does your child receive any special services at school (i.e. speech therapy, tutoring)? ☐ No ☐ Yes
If yes, describe: _____

Has your child ever repeated a grade? ☐ No ☐ Yes If Yes, which grade(s)? _____

Reason for repeating grade: _____

Describe child's strengths in school: _____

_____

Describe child's overall performance at school. _____

MEDICAL AND MENTAL HEALTH HISTORY:

Has your child had any serious accidents/injuries/illnesses involving such things as:

Yes	No	
☐	☐	convulsions
☐	☐	high fevers
☐	☐	loss of consciousness
☐	☐	fainting
☐	☐	headaches
☐	☐	chronic fatigue
☐	☐	head injuries
☐	☐	seizures
☐	☐	ear problems
☐	☐	meningitis
☐	☐	other:_____

Was your child born prematurely? ☐ No ☐ Yes If yes, how early? _____

Any developmental problems? ☐ No ☐ Yes If yes, explain: _____

Has your child ever required hospitalization? ☐ No ☐ Yes

If Yes, please explain: _____

Who is your child's primary care physician? _____

When was his/her last physical? _____

Does your child have any allergies? ☐ No ☐ Yes

If yes, please describe: _____

List any medications the child has taken (check current if still taking):

Medication	Dose	Frequency	Reason for Taking	Current
				☐
				☐
				☐
				☐

Does your child have any health problems at this time? ☐ No ☐ Yes

If yes, please explain :_____

Has your child ever been evaluated by a psychologist privately or through the school system?

☐ No ☐ Yes

If yes, when, and by whom? _____

What do you remember of the results/recommendations? (Please bring a copy to the evaluation if you have these results)

_____

_____

List any psychiatric diagnosis your child has been given including the child's age at diagnosis and who made the diagnosis:

Diagnosis	Age of Diagnosis	Person who made diagnosis

Has your child previously seen a therapist or psychiatrist? ☐ No ☐ Yes

If yes, list any therapy or counseling the child has participated in (check current if still attending):

Name of Therapist or Psychiatrist	Ages When Attended	Reason	Current
			☐
			☐
			☐

Has your child ever had any psychiatric hospitalizations? ☐ No ☐ Yes

If yes, please list any:

Name of Hospital	Age at Hospitalization	Length of Stay	Reason for Hospitalization

Does the child or child's family (include siblings, parents, grandparent, aunts, uncles, and cousins) have a history of (check all that apply and indicate relationship to family member where applicable):

Child	Family	
☐	☐	High blood pressure _____
☐	☐	High cholesterol _____
☐	☐	Heart attack (age occurred) _____
☐	☐	Other heart disease _____
☐	☐	Asthma, other lung problems _____
☐	☐	Stroke _____
☐	☐	Blood clots/bleeding disorder _____
☐	☐	Migraines/other neurologic _____
☐	☐	Cancer (list type) _____
☐	☐	Diabetes _____
☐	☐	Thyroid disease _____
☐	☐	Head Injury _____
☐	☐	Seizures _____

☐ ☐ Depression _____

☐ ☐ Bipolar disorder _____

☐ ☐ Anxiety/OCD _____

☐ ☐ ADHD _____

☐ ☐ Autism/Asperger's _____

☐ ☐ Schizophrenia or other psychotic disorder _____

☐ ☐ Suicide _____

☐ ☐ Alcoholism/Drug Abuse _____

☐ ☐ Sexual Abuse _____

☐ ☐ Physical Abuse _____

☐ ☐ Emotional Abuse _____

☐ ☐ Neglect _____

☐ ☐ Domestic Violence _____

☐ ☐ DCS Involvement _____

☐ ☐ Frequent Moving _____

☐ ☐ Homelessness _____

☐ ☐ Criminal History _____

☐ ☐ Other (explain) _____

Explain any items that were checked:

_____

_____

List any major life stressors (e.g., death of family member, unemployment, major accident, house fire, crime victim, etc.) that your family has faced during the child's life and include child's age:

_____

_____

Does your child or anyone in your family have any past or current legal issues or concerns? ☐ No ☐ Yes

If yes, please explain:_____

<u>SPEECH/LANGUAGE SECTION</u>

Do you have trouble finding the exact words to say when speaking or writing?

☐ No ☐ Yes If yes, how early? _____

Is it hard for you to follow complex directions?

☐ No ☐ Yes If yes, how early? _____

Is it difficult for you to keep information in your memory long enough to complete a task? (i.e. a math problem, shopping list)

☐ No ☐ Yes If yes, how early? _____

Do you have difficulty understanding jokes, humor, and figurative language?

☐ No ☐ Yes If yes, how early? _____

Do you have difficulty interacting with others like starting a conversation, maintaining a conversation or ending a conversation?

☐ No ☐ Yes If yes, how early? _____

Do you have difficulty keeping yourself organized?

☐ No ☐ Yes If yes, how early? _____

ADOELSCENT'S PEER RELATIONSHIP HISTORY:

Please describe your child's friend group: _____

_____

_____

What does your child like to do with his/her friends? _____

_____

_____

Any concerns about your child's friends? ☐ Yes ☐ No ☐ Possibly ☐ Not sure

_____

ABOUT YOUR CHILD:

What do you consider to be your child's strengths? _____

_____

List any significant life influences:

_____

_____

What is your child's relationship like with you?

_____

_____

CURRENT VISIT

For what issues are you currently seeking help for your child and when did they start? _____

_____

What kind of help do you expect from your child's treatment at Nashville Child and Family Wellness Center?_____

_____

_____

How long do you expect treatment for the current issue(s) to last?_____

_____

Any other comments? _____

_____

_____

Name of person(s) completing this form/Relationship to child: _____

REFERRAL INFORMATION

Referral Source: _____ Relationship: _____

May I contact them about your consultation with me? ☐ Yes ☐ No

Reason for Referral: _____

_____