Mielke and Weeks Psychological Services

Child and Adolescent Life History Questionnaire

The purpose of this questionnaire is to obtain a comprehensive understanding of your (your child's) life experience and background. Responding to these questions as completely as you can will benefit you (your child) through the development of a treatment program suited to your (your child's) specific needs.

Date: ____________________

Person completing form: ____
Relationship to child or adolescent: _______________________________________
How did you find Mielke and Weeks Psychological Services? ________________________________

Name (of child/adolescent): ______________________________________
Address: ____
Home Phone: _________________Work Phone: ____________________
Cell Phone: ____________________
Date of Birth: ____________________ E-mail: ______________________

Legal Guardian(s)
Name(s):____
Address: _______________________________________
Home: __________________________Work Phone: ____________________
Cell Phone: _______________________E-mail: ____________________________
Legal Guardian Status:
Biological Parent(s), Adoptive Parent(s), Foster Parent(s), Other ______________________
*please circle or write in blank to indicate status.

If shared/joint legal custody, please supply contact information for other legal guardian:
Name(s):____
Address: _______________________________________
Home: __________________________Work Phone: ____________________
Cell Phone: _______________________E-mail: ____________________

Emergency Contact
Name: __________________________________ Relationship: ____________________
Home Phone: ____________________ Work Phone: ____________________
Cell Phone: ____________________

Primary Insurance
Name of Subscriber: ______________________________ Relationship: ____________________
Subscriber's Date of Birth: ____________________ Employer: ____________________
Effective Date: ____________________
Contract Number: ____________________ Group Number: ____________________

Secondary Insurance
Name of Subscriber: ______________________________ Relationship: ____________________
Subscriber's Date of Birth: ____________________ Employer: ____________________
Effective Date: ____________________
Contract Number: ____________________ Group Number: ___________________

Please describe the problem that brings you here:
____
____
____
____

When did your problem begin?
____
____

Please rate the severity of your problem on the scale below:
Low 0 1 2 3 4 5 6 7 8 9 10 High

What are your current goals for treatment?
____
____
____

General Information (“YOU” is referring to the person coming into treatment)
How long have you lived at your current address? _________________________
Of what race do you consider yourself? _________________________
Do you have a religious preference? Yes ___ No ___ Religion: ____________________
If no, did you have a religious preference in the past? Yes ___ No ___ Religion: ______________

Medical History
What is your height? _____ feet _____ inches What is your weight? __________ pounds

How many times have you been hospitalized for a medical problem in your life? _____

Date	Length of Stay	Reason for Hospitalization
__________	_____________________	__________________________________
__________	_____________________	__________________________________
__________	_____________________	__________________________________
__________	_____________________	__________________________________

Have you had any medical problems when you were younger? Yes ___ No ___
If yes, explain: ____
____

Do you have any current medical problems? Yes ___ No ___
If yes, explain: ____
____
____
____

Are you taking any prescribed medication for a physical problem? Yes ___ No ___
Current Medications:
____
____
____
____

Are your immunizations complete and up to date? Yes ___ No ___
If no, explain: ____

Circle any of the following health problems that you **have now** or have **had in the past**:

	Age		Age		Age
high fevers	_____	flu	_____	pneumonia	_____
weight problems	_____	dental problems	_____	allergies	_____
encephalitis	_____	skin problems	_____	meningitis	_____
asthma	_____	convulsions	_____	headaches	_____
accident prone	_____	stomach problems	_____	head injury	_____
fainting	_____	high/low blood pressure	_____	dizziness	_____
sinus problems	_____	tonsils removed	_____	heart problems	_____
earaches	_____	hyperactivity	_____	diabetes	_____
hearing problems	_____	speech problems	_____	vision problems	_____

Other: ____
____
____

Developmental History

Did your mother use alcohol and/or drugs during pregnancy? Yes ___ No ___ Unknown ___
Did your mother use tobacco products during pregnancy? Yes ___ No ___ Unknown ___
Did your mother have any problems during pregnancy? Yes ___ No ___ Unknown ___
If yes, explain: ____
Did your mother have any problems during labor and/or delivery? Yes ___ No ___ Unknown ___
If yes, explain: ____
Did you have any problems immediately after birth? Yes ___ No ___ Unknown ___
If yes, explain: ____

Early Social Development

How was your relationship with brothers, sisters or other children?
____
____

Describe special interests, habits and/or fears:
____
____

Educational History

What is the highest grade you've completed in school? ______________________

Name of School	City/State	Dates Attended	Completed Grade
___________	___________	___________	___________
___________	___________	___________	___________
___________	___________	___________	___________
___________	___________	___________	___________
___________	___________	___________	___________

Type of classes in school:
Regular ___ Learning Disability ___ Emotionally Handicapped ___
Continuation ___ Opportunity ___ Other: ______________________

Did you skip a grade? Yes ___ No ___ Did you repeat a grade? Yes ___ No ___
If yes, explain: ___
Have you ever had any specific learning difficulties? Yes ___ No ___
If yes, explain: ___
Have you ever had a tutor or other special help with schoolwork? Yes ___ No ___
If yes, explain: ___
Do you attend school on a regular basis? Yes ___ No ___
If yes, explain: ___
Do you enjoy school? Yes ___ No ___
If yes, explain: ___
Have you ever been expelled or suspended? Yes ___ No ___
If yes, explain: ___

What was the highest grade on your last report card? _____
What was the lowest grade on your last report card? _____
What is your favorite subject? ___
What is your least favorite subject? ___
Do you participate in after school activities? Yes ___ No ___
If yes, explain: ___
How many friends do you have at school? ___
Have you ever had any special testing in school? Yes ___ No ___
If yes, explain: ___

Employment History
Have you ever been employed? Yes ___ No ___
If yes, explain: ___
What has been your usual employment pattern in the past 3 years?
Full-time (35+ hours per week) ___ Part-time (less than 35 hours per week) ___
Only occasional work ___ Not working ___

Alcohol and Drug Use History

_____ Check here if there is no history or presence of alcohol or drug use.

How often have you used any of the following substances?

	Current Use (Number of days in past month)	Past Use (Number of days in average month)
Alcohol	___	___
Amphetamines	___	___
Barbiturates	___	___
Cocaine	___	___
Hallucinogens	___	___
Heroin	___	___
Inhalants	___	___
Marijuana	___	___
Sedatives	___	___
Tobacco	___	___
Other: ___	___	___

How many times have you been treated for alcohol problems? _____

Date	Length of Treatment	Length of Abstinence from Alcohol
______________	_________________________	____________________________
______________	_________________________	____________________________

How many times have you been treated for drug problems? _____

Date	Length of Treatment	Length of Abstinence from Drugs
______________	_________________________	____________________________
______________	_________________________	____________________________

Legal History

Was this treatment prompted or suggested by the criminal justice system? Yes ___ No ___
If yes, explain: ____
Have you ever been in trouble with the police? Yes ___ No ___
If yes, explain: ____
Have you ever appeared in juvenile court? Yes ___ No ___
If yes, explain: ____
Have you ever been on probation? Yes ___ No ___
If yes, explain: ____
Are you presently awaiting charges, trial or sentencing? Yes ___ No ___
If yes, explain: ____

Family History

Marital Status of Parents
Married ___ (How long? _______) Separated ___ Divorced ___ Never Married ___
Living Together ___ (How long? _______) Deceased ___ (Mother or Father? How long ago? _______)

Were you adopted? Yes ___ No ___
If yes, state age of adoption:____

Family Members

Name	Relationship	Age	Quality of Relationship	Living with you?
_________________	__________	_____	__________________	______________
_________________	__________	_____	__________________	______________
_________________	__________	_____	__________________	______________
_________________	__________	_____	__________________	______________
_________________	__________	_____	__________________	______________
_________________	__________	_____	__________________	______________
_________________	__________	_____	__________________	______________

Have you ever lived away from your family? Yes ___ No ___
If yes, explain: ____

With whom do you spend most of your free time?
Family ___ Friends ___ Alone ___ Other: ____

How many close friends do you have? _____

What do you like to do in your free time?

____
____

Has anyone ever abused you emotionally? Yes ___ No ___
If yes, explain: ____
Has anyone ever abused you physically? Yes ___ No ___
If yes, explain: ____
Has anyone ever sexually abused you? Yes ___ No ___
If yes, explain: ____
Have you had any serious conflicts with family members in the past 30 days? Yes ___ No ___
If yes, explain: ____
Have you had any serious conflicts with family members at other times in the past? Yes ___ No ___
If yes, explain: ____

Mental Health History

How many times have you been hospitalized for a mental health problem? _____

Date	Length of Stay	Reason for Hospitalization
__________	______________________	____________________________________
__________	______________________	____________________________________
__________	______________________	____________________________________

How many times have you been treated for a mental health problem in an outpatient setting? _____

Date	Length of Treatment	Reason for Treatment
__________	______________________	____________________________________
__________	______________________	____________________________________
__________	______________________	____________________________________
__________	______________________	____________________________________

Have you ever had a significant period of time in which you have experienced:
Serious depression? Yes ___ No ___
If yes, explain: ____
Serious anxiety? Yes ___ No ___
If yes, explain: ____
Hallucinations (saw something that other people didn't see)? Yes ___ No ___
If yes, explain: ____
Trouble understanding, concentrating or remembering? Yes ___ No ___
If yes, explain: ____
Trouble controlling violent behavior? Yes ___ No ___
If yes, explain: ____
Serious thoughts of suicide? Yes ___ No ___
If yes, explain: ____

Are you currently taking any medications for a mental health problem? Yes ___ No ___
If yes, list medications:

____
____
____
____

In the past, have you taken any medications for a mental health problem? Yes ___ No ___
If yes, list medications:

____
____
____

Any family history of any mental health difficulties? Yes ___ No ___
If yes, please explain:

____
____
____
____
____
____

Circle any of the following words or terms that apply to you:

worthless	useless	a “nobody”	“life is empty”	“can’t do anything right”
inadequate	stupid	incompetent	naïve	morally wrong
guilty	evil	hostile	full of hate	horrible thoughts
anxious	agitated	cowardly	unassertive	panicky
aggressive	ugly	unattractive	repulsive	depressed
lonely	unloved	misunderstood	bored	restless
confused	unconfident	in conflict	full of regrets	worthwhile
sympathetic	intelligent	attractive	confident	considerate

Other: ____
____
____

Signature: ____ Date: ____________________