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: ____

☐ 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: ____

☐ 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: ____

When was your child's last complete 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	______

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☐ ☐ 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:____

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:

____

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____

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:____

____

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