

**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: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

**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: \_\_\_\_\_

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**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):**

<u>Name</u>	<u>Relationship</u>	<u>Age &amp; DOB</u>	<u>Sex (M/F)</u>	<u>Quality of Relationship</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

**EDUCATIONAL HISTORY:**

Schools Attended (list all from Kindergarten to current)

<u>School Name</u>	<u>Grades Attended</u>	<u>Reason for Leaving School</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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                       |                       |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | convulsions           |
| <input type="checkbox"/> | <input type="checkbox"/> | high fevers           |
| <input type="checkbox"/> | <input type="checkbox"/> | loss of consciousness |
| <input type="checkbox"/> | <input type="checkbox"/> | fainting              |
| <input type="checkbox"/> | <input type="checkbox"/> | headaches             |
| <input type="checkbox"/> | <input type="checkbox"/> | chronic fatigue       |
| <input type="checkbox"/> | <input type="checkbox"/> | head injuries         |
| <input type="checkbox"/> | <input type="checkbox"/> | seizures              |
| <input type="checkbox"/> | <input type="checkbox"/> | ear problems          |
| <input type="checkbox"/> | <input type="checkbox"/> | meningitis            |
| <input type="checkbox"/> | <input type="checkbox"/> | 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
_____				<input type="checkbox"/>
_____				<input type="checkbox"/>
_____				<input type="checkbox"/>
_____				<input type="checkbox"/>

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: \_\_\_\_\_

Does your child have access to guns or firearms?  Yes  No

### SPEECH/LANGUAGE SECTION

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

No  Yes If yes, how early? \_\_\_\_\_

Is it hard for your child to follow complex directions?

No  Yes If yes, how early? \_\_\_\_\_

Is it difficult for your child 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? \_\_\_\_\_

Does your child have difficulty understanding jokes, humor, and figurative language?

No  Yes If yes, how early? \_\_\_\_\_

Does your child have difficulty interacting with others like starting a conversation, maintaining a conversation or ending a conversation?

No  Yes If yes, how early? \_\_\_\_\_

Does your child have difficulty keeping yourself organized?

No  Yes If yes, how early? \_\_\_\_\_

**ADOLESCENT'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: \_\_\_\_\_

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