

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: _____

Nashville Child and Family Wellness Center is a collection of independently practicing professionals, none of whom are responsible for the acts or omissions of the others.

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 & 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: _____

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
_____				<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: _____

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: _____
