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CONFIDENTIAL QUESTIONNAIRE – CHILD

DATE: _____ YOUR NAME: _____

PHONE (CELL): (_____) _____ PHONE (HOME): (_____) _____

ADDRESS: _____ APT #: _____ CITY: _____ STATE: _____ ZIP: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT YOUR CHILD:

FULL NAME: _____ NICK NAME: _____

DATE OF BIRTH: ____/____/____ PLACE OF BIRTH: _____

BEHAVIORAL EXCESSES:

WHAT DOES YOUR CHILD CURRENTLY DO TOO OFTEN, TOO MUCH, OR AT THE WRONG TIMES THAT GETS HIM/HER IN TROUBLE? PLEASE LIST ALL THE BEHAVIORS YOU CAN THINK OF. _____

BEHAVIORAL DEFICITS:

WHAT DOES YOUR CHILD FAIL TO DO AS OFTEN AS YOU WOULD LIKE, AS MUCH AS YOU WOULD LIKE, OR WHEN YOU WOULD LIKE? PLEASE LIST ALL THE BEHAVIORS YOU CAN THINK OF. _____

BEHAVIORAL ASSETS:

WHAT DOES YOUR CHILD DO THAT YOU LIKE? WHAT DOES HE/SHE DO THAT OTHER PEOPLE LIKE? _____

OTHERS CONCERNS:

DO YOU HAVE ANY OTHER CONCERNS ABOUT YOUR CHILD OR YOUR FAMILY THAT YOU HAVE NOT MENTIONED YET? _____

TREATMENT GOALS:

FROM YOUR PRECEDING LIST OF YOUR CHILD'S BEHAVIOR AND YOUR FAMILY CONCERNS, WHAT PROBLEM BEHAVIORS DO YOU WANT TO SEE CHANGE FIRST: AND HOW MUCH MUST THEY CHANGE FOR YOU TO BE SATISFIED? _____

FAMILY HISTORY:

THE NAME OF THE CHILD'S BIOLOGICAL PARENTS:

MOTHER: _____ FATHER: _____

WHO HAS LEGAL GUARDIANSHIP OF YOUR CHILD? _____

WHO ARE OTHER HOUSEHOLD MEMBERS WITH YOUR CHILD?

NAMES	AGES	RELATIONSHIP TO CHILD
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHO ARE YOUR CHILD'S SIGNIFICANT OTHERS NOT LIVING WITH YOUR CHILD?

NAMES	AGES	RELATIONSHIP TO CHILD
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE DESCRIBE ANY PAST COUNSELING OF EITHER YOUR CHILD OR ANY FAMILY MEMBER _____

DOES ANYONE IN THE CHILD'S FAMILY USE CURRENTLY (OR IN THE PAST) ANY TYPE OF DRUG, TOBACCO, OR ALCOHOL? YES NO

IF YES, PLEASE DESCRIBE: _____

EDUCATION HISTORY:

WHAT SCHOOL DOES YOUR CHILD ATTEND? _____

ADDRESS: _____

PHONE: _____ TEACHER'S NAME: _____ CURRENT GRADE: _____

WHAT DOES YOUR CHILD'S TEACHER SAY ABOUT HIM/HER? _____

OTHER SCHOOLS ATTENDED (INCLUDING PRE-SCHOOL): _____

HAS YOUR CHILD EVER REPEATED A GRADE? IF SO WHICH ONE(S)? _____

HAS YOUR CHILD EVER RECEIVED SPECIAL EDUCATION SERVICES? _____

HAS YOUR CHILD EXPERIENCED ANY OF THE FOLLOWING PROBLEMS AT SCHOOL?

- | | | | |
|----------------|-----------------------|-------------------|-------------|
| FIGHTING | LACK OF FRIENDS | DRUG/ALCOHOL | DETENTION |
| SUSPENSION | LEARNING DISABILITIES | POOR ATTENDANCE | POOR GRADES |
| GANG INFLUENCE | INCOMPLETE HOMEWORK | BEHAVIOR PROBLEMS | |

MEDICAL HISTORY:

WHAT IS THE NAME OF YOUR CHILD'S PRIMARY CARE PHYSICIAN? _____

ADDRESS: _____ PHONE: _____

DATE OF YOUR CHILD'S LAST MEDICAL EXAMINATION: _____

DID THE CHILD'S MOTHER SMOKE TOBACCO OR USE ANY ALCOHOL, DRUGS OR MEDICATIONS DURING THE PREGNANCY? IF SO, PLEASE LIST WHICH ONES: _____

DID THE CHILD'S MOTHER HAVE ANY PROBLEMS DURING THE PREGNANCY OR AT DELIVERY? IF SO, PLEASE DESCRIBE THEM: _____

HAS YOUR CHILD EXPERIENCED ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- | | | | |
|--------------------|-----------------------|----------------------|--------|
| A SERIOUS ACCIDENT | HOSPITALIZATION | SURGERY | ASTHMA |
| A HEAD INJURY | HIGH FEVER | CONVULSIONS/SEIZURES | |
| EYE/EAR PROBLEMS | MENINGITIS | HEARING PROBLEMS | |
| ALLERGIES | LOSS OF CONSCIOUSNESS | OTHER | |

PLEASE LIST ANY CURRENT MEDICAL PROBLEMS OR PHYSICAL HANDICAPS: _____

PLEASE LIST ANY MEDICATIONS YOUR CHILD TAKES ON A REGULAR BASIS: _____

OTHER HISTORY:

HAS YOUR CHILD EVER EXPERIENCED ANY TYPE OF ABUSE (PHYSICAL, SEXUAL, OR VERBAL)? IF SO, PLEASE DESCRIBE: _____

HAS YOUR CHILD EVER MADE STATEMENTS OF WANTING TO HURT HIM/HERSELF OR SERIOUSLY HURT SOMEONE ELSE? _____

HAS HE/SHE EVER PURPOSELY HURT HIMSELF OR ANOTHER? IF YES TO EITHER QUESTION PLEASE DESCRIBE THE SITUATION: _____

HAS YOUR CHILD EVER EXPERIENCED ANY SERIOUS EMOTIONAL LOSSES (SUCH AS A DEATH OF OR PHYSICAL SEPARATION FROM A PARENT OR OTHER CARETAKER)? IF YES, PLEASE EXPLAIN: _____

WHAT ARE SOME OF THE THINGS THAT ARE CURRENTLY STRESSFUL TO YOUR CHILD AND HIS/HER FAMILY?

ANY ADDITIONAL INFORMATION YOU BELIEVE MAY BE HELPFUL OR IMPORTANT: _____