Child and Adolescent Clinical Interview Questionnaire

CHILD INFORMATION:

Name: ___________________________  DOB: ___________

School: ___________________________  Grade: ___________

PARENT INFORMATION:

Name: ___________________________  Name: ___________________________

Age: ___________  Age: ___________

Occupation: ___________________________  Occupation: ___________________________

Relationship to Child: ___________  Relationship to Child: ___________

PRESENTING PROBLEM: ____________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

WHEN DID THE PROBLEM START: __________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Have you recently worried your child may have (please circle any relevant items below):

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<th>Yes</th>
<th>No</th>
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| ☐   |    | DEPRESSION (sad, irritable, hopeless, poor sleep, crying, social withdrawal/isolative behaviors, lack of interest in things, etc.)
| ☐   |    | MOOD SWINGS (energetic, little sleep, pleasure seeking, racing thoughts, too talkative, inappropriate sexual behaviors, grandiose, etc.)
| ☐   |    | ANXIETY (worries, restless, scared, poor sleep, obsessive thoughts and/or compulsive behaviors, frequent complaining of headaches and/or stomach aches, frequent school absences, etc.)

| ☐ Yes ☐ No | ATTENTION/HYPERACTIVITY PROBLEM (difficulty sustaining attention, hyperactive, impulsive, distractibility, not completing tasks) |
| ☐ Yes ☐ No | BEHAVIORAL PROBLEM (fights, anger, arguing, truancy, destruction of property, fire setting, etc.) |
| ☐ Yes ☐ No | SOCIAL ANXIETY (shy and/or afraid to be around others) |
| ☐ Yes ☐ No | REMEMBERING PAST TRAUMAS (frequent nightmares, intrusive and/or recurrent memories, etc.) |
| ☐ Yes ☐ No | ABNORMAL EATING BEHAVIORS (too much, too little, fear of weight gain, distorted body image, over exercising, etc.) |
| ☐ Yes ☐ No | AUTISM (social and language impairments, rigidity) |
| ☐ Yes ☐ No | DISSOCIATION (feeling outside your body or things are not real, etc.) |
| ☐ Yes ☐ No | PSYCHOSIS (hearing voices, seeing things, paranoia, delusions) |

FAMILY INFORMATION:

Siblings: __________________________________________
______________________________________________

Family members living in the home: __________________________________________
______________________________________________

Child’s relationship with family members: __________________________________________
______________________________________________

History of mental illness in family (e.g., depression, anxiety, ADHD, learning disabilities, etc.):
______________________________________________

Major medical illnesses in family: __________________________________________
______________________________________________

Additional family history (e.g., substance abuse, legal problems, domestic violence, etc.):
______________________________________________
DEVELOPMENTAL HISTORY:

Any prenatal complications:  

Birth history (e.g., full-term, birth weight, birth difficulties, etc.):  

Developmental Milestones:

Age when sat up alone: _______  Age when crawled: _______
Age when walked: _______  Age when spoke first word: _______
Age when used complete sentence: _______  Age when toilet trained: _______

Medical History:

Any serious accidents, head injuries, hospitalizations, surgeries, etc.:  

Concerns about hearing, vision, dental care:  

Medication History:

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<th>Medication</th>
<th>Dosage</th>
<th>Duration</th>
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EDUCATIONAL HISTORY:
Age first started school/daycare: ________________________________
Repeated any grades: ________________________________
Type of current classes (e.g., regular education, honors, special education, etc.):
__________________________________________________________________________
Current grades: ________________________________
Any after school activities (e.g., clubs, sports, groups): ________________________________
__________________________________________________________________________

PREVIOUS TREATMENT:
Ever seen counselor, therapist, psychiatrist (if yes): ________________________________
__________________________________________________________________________
Age when saw: ________________
Name/title/phone number of professional: ________________________________
Type/length of treatment: ________________________________