Oconee Center for Behavioral Health
1360 Caduceus Way
Building 400, Suite 102
Tel 706-286-8442
Fax 706-310-6907

Child/ Adolescent Questionnaire

Patient's Name: _____

Date of Birth: _____/_____/_____ Patient's Birthplace: _____ Sex: ☐M ☐F

Person completing this form: _____ Relation to Child: _____

Who Referred you to our Practice? _____

Please check all of the behaviors and symptoms that you consider problematic:

☐Distractibility	☐Change in appetite	☐Visual Hallucinations	☐Manipulative behavior
☐Hyperactivity	☐Withdrawal from people	☐Defiance	☐No/few friends
☐Impulsivity	☐Anxiety/worry	☐Aggression/fights	☐Eating problems
☐Boredom	☐Panic attacks	☐Homicidal thoughts	☐Sleep problems
☐Fear away from home	☐Frequent Arguments	☐Nightmares	☐Sadness/depression
☐Social discomfort	☐Irritability/anger	☐Toileting Problems	☐Hopelessness
☐Phobias	☐Peer/sibling conflict	☐Fire Setting	☐Thoughts of Death
☐Obsessive Thoughts	☐Stealing	☐Work/School Problems	☐Self-harm behaviors
☐Compulsive behavior	☐Destroys property	☐Legal Problems	☐Crying Spells
☐Racing thoughts	☐Running away	☐Sexual Behavior	☐Loneliness
☐Wide mood swings	☐Swearing	☐Computer addiction	☐Low self-worth
☐Suspicion/ paranoia	☐Curfew Violations	☐Alcohol/drug use	☐Fatigue
☐Hearing Voices	☐Lying	☐Lack of motivation	
☐Poor memory/ confusion	☐Recurring, disturbing memories	☐Other:	

Please Briefly describe the problems for which you are seeking help at this time:

_____

_____

_____

_____

_____

_____

_____

Approximate date of onset of problems: _____

Has the patient ever received outpatient mental health treatment? ☐ No ☐ Yes

If yes, please list in order, including Psychological, School, or IQ testing:

Clinician/ Doctor	Approximate Date of Evaluation/Treatment	Type of Evaluation	How Often did you visit said Clinician/Doctor

Has the patient ever received inpatient mental health treatment? ☐ No ☐ Yes

If yes, please list in order:

Hospital Name	Dates of Treatment	Reason for hospitalization

Has the patient ever threatened or attempted suicide? ☐ No ☐ Yes

If yes, please explain: _____

_____

_____

_____

Family Psychiatric History: Please note any history of ADHD, Learning Disorders, Depression, Bipolar Disorder, Anxiety Disorders, Obsessive-Compulsive Disorder, Tic/ Tourette's, Schizophrenia, Drug or Alcohol Abuse, Suicide attempts, or other Psychiatric Problems in your grandparents, parents, siblings, or 1st cousins.

Affected Family Member	Type of Mental Illness or SA	Treatment (If Any)

Please tell us a little about the Patient's childhood development:

Please answer the following as best as you can recall:
Pregnancy- Please check and describe any that apply to the mother's pregnancy with the patient:

☐ Received prenatal care _____
☐ Drank alcohol during pregnancy _____
☐ Smoked during pregnancy _____
☐ Used drugs during pregnancy _____
☐ Took Medications _____
☐ Infection(s) _____
☐ Nausea or vomiting _____
☐ Severe Emotional Distress _____
☐ Elevated blood pressure _____
☐ Diabetes of pregnancy _____
☐ Pre-eclampsia _____
☐ Premature labor _____
☐ Threatened miscarriage _____

Motor Development – sitting, crawling, walking, etc. ☐Normal ☐Fast ☐Slow
Speech and Language ☐Normal ☐Fast ☐Slow
Self-Help Skills- dressing, brushing, toileting, hygiene, etc. ☐Normal ☐Fast ☐Slow

Please tell us a little about the patient's social history:

Current City of Residence: _____
Currently Living with: ☐ Both Bio parents ☐Bio Father ☐Bio Mother ☐Other:
Please Explain Other: _____

Other Children in Family: ☐ No ☐ Yes If yes, please list:

Name of Child	Age

Is the patient adopted? ☐ No ☐ Yes
If yes, please explain the circumstances of the adoption: _____
_____
_____
_____

Has the patient ever experienced or witnessed any physical abuse, sexual abuse, or neglect?
☐ No ☐ Yes
If yes, please describe: _____
_____
_____
_____

Please tell us a little about the patient's school history:
Name of School: _____ Grade: _____

Current Academic Performance: ☐Good ☐Fair ☐Poor ☐N/A
Past Academic Performance: ☐Good ☐Fair ☐Poor
Past Behavioral Performance: ☐Good ☐Fair ☐Poor

Grades Repeated: _____

Has the patient ever been in any special education programs? ☐ No ☐ Yes
If yes, please explain: _____
_____
_____

Any known learning disabilities? ☐ No ☐ Yes
If yes, please explain: _____

Legal Problems:
Has the patient ever been arrested or had any legal charges files against them?
☐ No ☐ Yes
If yes, please explain: _____
_____
_____
_____

Substance Use:
Do you suspect that the patient has ever used tobacco, alcohol, or drugs? ☐ No ☐ Yes
If yes, please explain: _____
_____
_____
_____

Please tell us a little about the patient's medical history:

Who is the patient's Primary Care Doctor? _____

When was his/her last physical examination? _____

Does the patient have any current Medical Problems? ☐ No ☐ Yes

If yes, please explain: _____

_____

_____

_____

If applicable, please list any PAST psychiatric medications:

If we have not provided enough space please feel free to use the bottom or back of this page.

	Medicine #1	Medicine #2	Medicine #3	Medicine #4	Medicine #5
Name of Medicine					
Strength					
How many pills do you take at a time?					
How many times of day do you take this medicine?					
What does this medicine treat?					
Name of prescribing doctor?					

Please list any CURRENT Medications on the last page.

If applicable, please list any CURRENT medications:
If we have not provided enough space please feel free to use the bottom or back of this page.

	Medicine #1	Medicine #2	Medicine #3	Medicine #4	Medicine #5
Name of Medicine					
Strength					
How many pills do you take at a time?					
How many times of day do you take this medicine?					
What does this medicine treat?					
Name of prescribing doctor?					

_____ _____

Patient Signature Date

_____

Relationship to patient