Children's Resource Group / CRG
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Returning Clients Questionnaire

Child/Adolescent's Legal Name	Birth Date:	Today's Date:
Name/Nickname:	Child/Adolescent's Race:	Pronouns:
Gender Identity:	Sex Assigned at Birth/Legal Sex:	Sexual Orientation:
Current School Attending:	Current Grade Placement:	Child's Religious/Cultural Affiliation:
Person Completing Questionnaire:	Relationship to Patient:	Who referred you here?

HOW DID YOU HEAR ABOUT CRG?

- ☐ Family Dr. (Dr.'s name: _____)
- ☐ Therapist (Therapist's name: _____)
- ☐ School (School name: _____)
- ☐ Family member (Name: _____)
- ☐ Friend / Coworker (Name: _____)
- ☐ CRG Website
- ☐ Other (_____)

PURPOSE OF EVALUATION

What are your questions or concerns regarding your child/adolescent?

FAMILY OF ORIGIN INFORMATION

Legal Guardian /Parent#1 Name: _____Relationship:_____

Partner/Stepparent Name (if not parent #2)_____

Legal Guardian/Parent #2 Name: _____Relationship:_____

Partner/Stepparent Name (if not parent #1)_____

Is child/adolescent biologically related to both parents? Yes/no Comments:

Please list the Name and Relationship of additional individuals that will be involved in your child's care:

_____

_____

Individuals other than custodial parents will require a completed release of information to be involved in communication, billing, and treatment regarding the patient.

Parents are:		Date
Married	◯	_____
Single	◯	_____
Partnered	◯	_____
Separated	◯	_____
Divorced	◯	_____
Widowed	◯	_____

* Please describe any current legal custody/visitation arrangements and provide a copy of the custody decree or court order:

Is your child/adolescent a foster child?_____ Yes _____ No Length of time in your home _____

Is your child/adolescent adopted? _____ Yes _____ No Age at adoption _____

If a foster child or adopted, has this been discussed with your child/adolescent?_____ Yes _____ No

Who has legal guardianship of the child/adolescent?

Who provides primary care to the child/adolescent when parent(s) are at work?

Please **list <u>all</u> persons** presently living in your home:

Name	Sex	Age	Relation to Child	Present or Highest Grade Completed	Occupation

Please list immediate family members **not** living in your home:

Name	Sex	Age	Relation to Child	Present or Highest Grade Completed	Occupation

Has your family experienced any of the following difficulties?

	Yes	No	**Please explain**
Death of a family member	○	○	
Serious illness	○	○	
Marital problems	○	○	
Unemployment/Financial Trouble	○	○	
Abuse (sexual, verbal, physical, and or emotional)	○	○	
Neglect/Abandonment	○	○	
Other significant events/losses/changes	○	○	
Significant changes due to the 2020 Coronavirus Pandemic	○	○	

FAMILY HISTORY

Please list family history for blood relatives for any of the following:

	None	Yes	Relation to Child	Comments
Seizure disorders				
Learning difficulties				
ADHD/ADD				
Depression				
Suicide attempts (please explain)				
Bipolar Disorder				
Tic disorders				
Anxiety difficulties				
Schizophrenia/Psychosis				
Substance use/Alcoholism/Illegal prescriptions				
Autism Spectrum Disorder				
Eating Disorders/Obesity				
Other Severe Mental Health				
Other medical diagnoses				

Please list your child's current medical providers, mental health providers or other therapists?

_____

_____

_____

_____

_____

PAST MEDICAL ILLNESSES

	Yes	No	Comments
Has your child/adolescent **ever been hospitalized**? If yes, please describe, including **child's age**.			
Has your child/adolescent ever had any **serious accidents** requiring medical care? If yes, please describe, including your child's age. (Include broken bones.)			
Has your child/adolescent had or currently have any **serious or chronic illnesses**? Please describe.			
Has your child/adolescent ever had a **seizure or convulsion**? If yes, please describe, including child's age.			
Has your child/adolescent ever had **tics**? (Facial movements, eye-blinking, etc.)			
Does your child/adolescent have any known **allergies**? Please describe.			
Do you feel your child/adolescent has **trouble hearing**? If yes, please explain.			
Do you feel your child/adolescent has **trouble seeing**? If yes, please explain.			
Are you concerned about your child/adolescent's **eating habits**? If yes, please describe.			
Are you concerned about your child/adolescent's **sleep habits**? If yes, please describe; include trouble falling asleep, not being able to sleep in own room, nightmares, awakenings, snoring, and trouble waking up.			
Does your child/adolescent have **headaches** more than once a week?			

	Yes	No	Comments
Is your child/adolescent presently taking **any medication**? If yes, please **list the medications, dosages**, **by whom it was prescribed and why**. *If taking more than three medications, please list additional medications in the space provided below.			**Medication 1** Name: Dose: Prescribed by: Reason: **Medication 2** Name: Dose: Prescribed by: Reason: **Medication 3** Name: Dose: Prescribed by: Reason:

Please list any additional medications here:

Does your child/adolescent have any **previous diagnoses**? ____ Yes ____ No
*If so, please use the space below to **list each diagnosis, date of diagnosis, and the provider who made each diagnosis**.

EDUCATIONAL HISTORY

Please list your child's schools:

Name Grade Levels

Preschool/Daycare: _____

_____

Kindergarten: _____

_____

Elementary: _____

_____

Middle School: _____

_____

High School: _____

_____

LEARNING AND PSYCHOLOGICAL/MEDICAL INTERVENTIONS

Has your child/adolescent **received treatment or been evaluated** for any of the following?

	Yes	No	Dates	Where and/or Who
Educational/Psychological testing				
Speech/language therapy				
Physical therapy				
Occupational therapy				
Tutoring				
Counseling/Psychotherapy				
Psychiatry				
Restrictive Diet/Supplements				
Other (please list)				

Has your child/adolescent ever been **retained or held back** a grade? ____ Yes ____ No

Does your child/adolescent receive **special education services (IEP) or have a 504 Plan**? *If so, please attach a copy of the most current IEP/504. ____ Yes ____ No

Please list your child/adolescent's most **current grades/GPA**: _____

Reading ____	History/ Social Studies ____	Writing ____
Spelling ____	Math ____	Science____

Please list any **additional classes and current grades** below.

Name of **elementary school age** child's current primary teacher_____

Please describe your child's **study habits**:

Have you noticed any **changes in academic performance** recently?

SOCIAL HISTORY

How does your child/adolescent **entertain themself**? Please list **hobbies or activities** they enjoy:

Describe your child/adolescents' **interactions with family members**:

Describe your child/adolescents' **interactions with peers**:

Please describe your child/adolescent's present **peer group**:

Please list **extracurricular activities** which your child/adolescent has participated in during the last six months:

Have you noticed any **changes in your child/adolescent's emotions or behaviors? Please explain.**

Please describe what you consider to be your child/adolescent's **strengths**:

Do you have concerns regarding possible **alcohol and/or drug use**? _____ Yes_____ No _____N/A

CHILD/ADOLESCENT'S BEHAVIOR

Please indicate any of the following behaviors that you observe with your child/adolescent; please describe any areas of concern:

Vanderbilt Parent Rating Scale

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	○	○	○	○
2. Has difficulty staying focused on what needs to be done	○	○	○	○
3. Does not seem to listen when spoken to directly	○	○	○	○
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	○	○	○	○
5. Has difficulty organizing tasks and activities	○	○	○	○
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	○	○	○	○
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	○	○	○	○
8. Is easily distracted by noises or other stimuli	○	○	○	○

Symptoms	Never	Occasionally	Often	Very Often
9. Is forgetful in daily activities	○	○	○	○
10. Fidgets with hands or feet or squirms in seat	○	○	○	○
11. Leaves seat when remaining seated is expected	○	○	○	○
12. Runs about or climbs too much when remaining seated is expected	○	○	○	○
13. Has difficulty playing or beginning quiet play activities	○	○	○	○
14. Is "on the go" or often acts as if "driven by a motor"	○	○	○	○
15. Talks too much	○	○	○	○
16. Blurts out answers before questions have been completed.	○	○	○	○
17. Has difficulty waiting his/her turn.	○	○	○	○
18. Interrupts or intrudes in on others' conversations and/or activities	○	○	○	○
19. Argues with adults	○	○	○	○
20. Loses temper	○	○	○	○
21. Actively defies or refuses to go along with adults' requests or rules	○	○	○	○
22. Deliberately annoys people	○	○	○	○
23. Blames others for his or her mistakes or misbehaviors	○	○	○	○
24. Is touchy or easily annoyed by others	○	○	○	○
25. Is angry or resentful	○	○	○	○
26. Is spiteful and vindictive (wants to get even)	○	○	○	○
27. Bullies, threatens or intimidates others	○	○	○	○
28. Starts physical fights	○	○	○	○
29. Lies to get out of trouble or to avoid obligations (i.e., "cons" others)	○	○	○	○
30. Skips school without permission	○	○	○	○
31. Is physically cruel to people	○	○	○	○
32. Has stolen things that have value	○	○	○	○
33. Deliberately destroys others' property	○	○	○	○
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	○	○	○	○
35. Is physically cruel to animals	○	○	○	○
36. Has deliberately set fires to cause damage	○	○	○	○
37. Has broken into someone else's home, business, or car	○	○	○	○
38. Has stayed out at night without permission	○	○	○	○
39. Has run away from home overnight	○	○	○	○
40. Has forced someone into sexual activity	○	○	○	○
41. Is fearful, anxious, or worried	○	○	○	○
42. Is afraid to try new things for fear of making mistakes	○	○	○	○
43. Feels worthless or inferior	○	○	○	○
44. Blames self for problems, feels guilty	○	○	○	○
45. Feels lonely, unwanted, or unloved; complains that "no one loves him/her"	○	○	○	○

Symptoms	Never	Occasionally	Often	Very Often
46. Is sad, unhappy, or depressed	○	○	○	○
47. Is self-conscious or easily embarrassed	○	○	○	○
Additional Items:				
48. Has done cutting and/or self-injurious behaviors	○	○	○	○
49. Has made suicide attempts	○	○	○	○

Thank you for completing this form.