TRIAD ASSOCIATES, P.C.

Social Medical Questionnaire – Child/Adolescent

I. General Information

Name: ______________________________ **Case Number:** ____________________

Address: ______________________ **City:** ______________ **State:** ________ **Zip:** ______________

Telephone (Home): ____________________ **(Cell):** __________________ **School:** __________________________

Birth Date: ______________________ **Age:** ___________ **Sex:** __________ **Grade:** __________________________

Responsible Party: ____ **Relationship:** ___________________________

Emergency Contact: _______________________________________ **Telephone:** ____________________________

Marital Status of Parents/Guardian: ______ **Single** _____ **Separated** _____**Married** _____**Divorced** ____**Widowed**

______**Unmarried, living with significant other**

Divorce Information (list the date of any divorce and the client's age at the time):___________________________

____

List all people living in the home (use back if needed)

Name	Age	Highest Grade	Relationship to Client

II Referral Info

Who referred you? ____

Please indicate the primary reason for seeking therapy and what you hope to accomplish through therapy:

____

____

Has child ever sought therapy before? __________ **Yes** ________ **No**

If yes, at what age, with whom and what were the results: ____

____

How do you see yourself and other family members being involved in the treatment process? ________________

____

Client Name ______________________________
Case Number _____________________________

III Educational History

Has the client ever been identified as having a cognitive deficit or learning disability? _________ Yes ________ No
If yes, please explain: ____
____
Schools attended and progress?
Preschool: ____
Elementary: ____
Middle School: ____
High School: ____
Describe the client's current performance in school: ____
____

IV. Religious, Cultural, and Ethnic History

Is religion important in the development of the client? ________ Yes _______No
Please explain: ____
____
List child/adolescents ethnic background: ____
____
Explain cultural influences on client: ____
____
Describe relationships with parents and siblings: ____
____
Describe client's relationship with peers: ____
____
Are there any problems experienced in the school, home or neighborhood environment? ____________________
____
Describe client's activities and interests: ____
____

Has the client ever abused drugs or alcohol? ____________Yes __________No
If yes, describe (include substance, amount frequency, first and last use, previous treatment, ect.)

Substance	Amount	Frequency	First Use	Last Use

Nicotine use? ________Yes _______ No If yes, amount: ____

Caffeine use? ________Yes _______ No If yes, amount: ____

V. Medical

Has the client been diagnosed with any allergies? _______ Yes _______No
If yes, please list: ____
Are the client's immunizations up to date? ________Yes ________ No
If no, please explain: ____

Client Name: ______________________________
Case Number: ______________________________

Has the client had any significant childhood diseases, illnesses, accidents or operations? ________Yes _______No
If yes, please describe: ____
Does the client have immediate health concerns? _______Yes _______no
If yes, please describe: ____
When was the client's last complete physical? ___________________________________
What were the results? ____
Please list all the medications (prescription or non-prescription) the client is currently taking:

Name	Strength	Frequency

(Use back if more space is needed)
Describe history of mental illness or addiction in the family: ____
____
Has the client met developmental milestones at age appropriate levels? _________Yes ________No
If no, please explain: ____
Was there pre-natal exposure to alcohol, tobacco or other drugs? ________Yes ________No
If yes, please explain: ____
Has the client been identified with any of these functioning problems?
Speech: _______ Yes _______No Hearing: ________Yes ________No Visual: _______ Yes _______No
If yes, please explain: ____

VI. Emotional and Behavioral Functioning

Check any symptoms experienced in the past year:

	Decrease in energy		Restlessness		Hopelessness		Excessive guilt
	Panic Attacks		Cruelty		Loss of pleasure		Depressed Mood
	Anxiety		Sleep disturbance		Withdrawn		Oppositional
	Poor concentration		Indecisive		Mood swings		Violation of rules
	Legal Problems		Irritability		Helplessness		Eating disturbance
	Impulsivity		Worrying		Aggression/Rage		Tearfulness
	Substance abuse		Ritualistic Behavior		Low self-esteem		Low Motivation
	Other:						

Suicide/Homicide Assessment:
Does the client have suicidal/homicidal thoughts? _______ Yes ________No
Does the client have suicidal/homicidal urges? _______ Yes ________No
Does the client have suicidal/homicidal plans? _______ Yes ________No
Has the client recently made a suicidal/homicidal attempt or gesture? _______ Yes ________No
Does the client have a history of suicidal/homicidal thoughts or urges? _______ Yes ________No
Has the client made any suicidal/homicidal attempts in the past? _______ Yes ________No

____ ______________________________
Signature of Informant Date Relationship to Client

I have reviewed this questionnaire with the Client/Informant: ____
Clinician's Signature/Credentials Date
(Coordinator of Services)

Revised 05/22/14