

# OZARK GUIDANCE CHILD QUESTIONNAIRE

Chart # \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_  
First Middle Last

## **Parents address if different from child's, and parents employment information:**

Mother's address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Mother's place of employment: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Father's address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Father's place of employment: \_\_\_\_\_ Occupation: \_\_\_\_\_

## **Caretaker/Child Care:** \_\_\_\_\_

## **If parents are separated or divorced:**

Date of separation: \_\_\_\_\_ Date of divorce: \_\_\_\_\_

## **If divorced, has either parent remarried?**

Date or remarriage of mother: \_\_\_\_\_ Father \_\_\_\_\_

Frequency of non-custodial visits with this child \_\_\_\_\_

## **Custody Information:**

Who has legal custody of the child if the child is not in the custody of the parents? \_\_\_\_\_

How did this custody arrangement come about? \_\_\_\_\_

Frequency of parental visits with child? \_\_\_\_\_

## **Social support system/community resources for child: Please check all that apply.**

- Church (please specify) \_\_\_\_\_  
 School (please specify) \_\_\_\_\_  
 Sports programs (please specify) \_\_\_\_\_  
 Community programs (please specify) \_\_\_\_\_  
 Other adult outside the home (please specify) \_\_\_\_\_  
 Community mental health centers or counseling clinics (please specify) \_\_\_\_\_  
 Therapeutic day treatment (please specify) \_\_\_\_\_  
 Other (please specify) \_\_\_\_\_

Please list child's hobbies, recreational activities, and interests: \_\_\_\_\_

What type(s) of discipline do you use most frequently with your child? \_\_\_\_\_

How does this child relate to his/her peers? \_\_\_\_\_

Substance Abuse: Is this child affected by the use of substances, either by self or family member(s)?  Yes  
 No If yes, please describe the impact. \_\_\_\_\_

Are there sexual or relationship issues that this child wants considered in his/her treatment?  
\_\_\_ Yes \_\_\_ No. If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

**Learning Needs/Education Screen:**

What is the preferred language? \_\_\_\_\_

Does this child have any problems in school? \_\_\_\_\_

Is there a history of learning disabilities? \_\_\_ Yes \_\_\_ No

Is there any other learning need? If so, please state:

Is receiving educational materials about issues related to treatment important? \_\_\_ Yes / \_\_\_ No

Is an interpreter needed? \_\_\_ Yes \_\_\_ No

Is there a learning preference? (Please circle)

- Visual (seeing)
- Auditory (hearing)
- Hands-on Tasks (doing)
- Unsure

Is there a topic(s) for which you would like additional information such as treatment planning, health and safety practices, medication use, nutrition or other? \_\_\_ Yes \_\_\_ No If yes, please explain

**Spiritual/Religious:**

Are there cultural and/or religious concerns that you want considered in treatment? \_\_\_ Yes \_\_\_ No Please explain: \_\_\_\_\_

Please circle the child's religious orientation: Protestant, Jewish, Catholic, Hindu, Muslim, Jehovah Witness, Latter Day Saints, None, Other \_\_\_\_\_

**Physical Health Screen:**

Family Physician: \_\_\_\_\_ City: \_\_\_\_\_

Other Physicians: \_\_\_\_\_ City: \_\_\_\_\_

\_\_\_\_\_ City: \_\_\_\_\_

\_\_\_\_\_ City: \_\_\_\_\_

Date of child's last physical: \_\_\_\_\_ who performed: \_\_\_\_\_

Child's Weight \_\_\_\_\_

Please list any complications in pregnancy with this child, if applicable \_\_\_\_\_  
\_\_\_\_\_

Please list any complications in the delivery of this child, if applicable.  
\_\_\_\_\_

Please list problems this child had during the first weeks after he or she was born, if applicable.  
\_\_\_\_\_

Please list development delays this child has (i.e., walking, talking, language, etc.), if applicable.  
\_\_\_\_\_

Please list current health problems(s), if applicable. \_\_\_\_\_  
\_\_\_\_\_

Child's Sleeping Pattern:

Average number of hours per night? \_\_\_\_\_ Is the child receiving enough sleep? \_\_\_\_\_

Health of Mother: \_\_\_Poor \_\_\_Fair \_\_\_Good \_\_\_Excellent \_\_\_Deceased

Health of Father: \_\_\_Poor \_\_\_Fair \_\_\_Good \_\_\_Excellent \_\_\_Deceased

Medications currently being taken by the child including prescription, over the counter and herbals:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the child allergic or sensitive to any medications?: \_\_\_Yes \_\_\_No If Yes, please list. \_\_\_\_\_

\_\_\_\_\_

Please place a check mark to indicate any Emotional/Medical Problems that this child is experiencing or has experienced and list any relative that has ever had any of the following illnesses:

<u>Client</u>	<u>Relative (list relationship)</u>	<u>Client</u>	<u>Relative (list relationship)</u>
___ Cancer _____	_____	___ Lung Illness _____	_____
___ Eating Disorder _____	_____	___ Hearing Problems _____	_____
___ Diabetes _____	_____	___ Depression _____	_____
___ Ulcers _____	_____	___ Mental Illness _____	_____
___ Heart Trouble _____	_____	___ Short Attention Span _____	_____
___ High Blood Pressure _____	_____	___ Hyperactivity _____	_____
___ Kidney Problems _____	_____	___ Impulsive Behavior _____	_____
___ Liver Problems _____	_____	___ Epilepsy _____	_____
___ Venereal Disease _____	_____	___ Headaches _____	_____
___ Vision Problems _____	_____	___ Head Injuries _____	_____
___ Stroke _____	_____	___ Alcoholism _____	_____
___ Thyroid Problems _____	_____	___ Drug Problem _____	_____
___ Intestinal Problems _____	_____	___ Learning Disabilities _____	_____
___ Back Pain _____	_____	___ Allergies _____	_____
___ Other _____	_____	___ Other _____	_____

Give significant details for previously listed illnesses or symptoms: \_\_\_\_\_

\_\_\_\_\_

List frequent minor childhood illnesses: \_\_\_\_\_

\_\_\_\_\_

<u>Other Occupants in the Home</u>	<u>Age</u>	<u>Health</u>		
_____	_____	___ Poor ___ Fair	___ Good	___ Excellent
_____	_____	___ Poor ___ Fair	___ Good	___ Excellent
_____	_____	___ Poor ___ Fair	___ Good	___ Excellent
_____	_____	___ Poor ___ Fair	___ Good	___ Excellent
_____	_____	___ Poor ___ Fair	___ Good	___ Excellent
_____	_____	___ Poor ___ Fair	___ Good	___ Excellent

**Pain Screen:** Does this child have physical pain for which he/she has not received care?

Yes  No If yes, please explain \_\_\_\_\_

**Nutrition Screen:**

Number of meals per day \_\_\_\_\_ Number of snacks per day \_\_\_\_\_

**Please place a check mark to indicate problem areas:**

List # One

- Recent loss of appetite
- Weight problems such as unexplained weight gain or loss
- Recent loss of smell sensitivity
- Problems chewing or swallowing
- Chronic constipation
- Purging
- Chronic diarrhea
- Binging
- Recent loss of taste
- Frequent nausea or vomiting

List #Two

- Use of vitamins or other supplements
- Special diet
- Food allergies
- Skipping meals frequently
- Lack of money to buy enough food needed
- Eating alone
- Hoarding
- Frequent consumption of inadequate meals
- Other \_\_\_\_\_

**Does this child use any of the following?** Please indicate the amount of his/her present use (i.e., drinks, packs per day, etc.):

Coffee \_\_\_\_\_ Tea \_\_\_\_\_  
Soft Drinks with Caffeine \_\_\_\_\_ Alcohol \_\_\_\_\_  
Nicotine \_\_\_\_\_

**Child's Legal Screen:**

To your knowledge, has this child been a victim of a crime, abuse, or neglect?  Yes  No

Has this child been involved in any legal issues?  Yes  No

**If yes, please circle all that apply:**

Misdemeanor	Felony	Probation	Parole	Civil Suit	Disability Hearing
Guardianship	Involuntary Commitment	Custody	Restraining order	Divorce	

**If yes to any of the above, was the legal concern related to: (please circle)**

Alcohol	Drugs	DHS/DCFS	Social Services	Child Abuse
Domestic Violence	Juvenile Court	Foster Care Placement	Adult Abuse	Disability

**Ozark Guidance Child Questionnaire  
Therapist Review of Screening Questions  
Referral Criteria**

**Date:** \_\_\_\_\_

**MR #:** \_\_\_\_\_

**Client Name:** \_\_\_\_\_

**Instructions:** This is the decision page for the child questionnaire to be completed by the mental health professional as part of the assessment process. This page **MUST BE ATTACHED** to the completed questionnaire for imaging into the Electronic Medical Record (EMR).

***PRIMARY THERAPIST'S SIGNATURE IS REQUIRED***

**Nutrition:** Instruct patient/guardian to contact the primary care provider if any items are checked in list one.

**Pain:** Instruct patient/guardian to contact the primary care provider If yes to the pain question.

**Physical Health Screening:** Instruct patient/guardian to contact the primary care provider for any current medical conditions checked on the list for which the client is not currently receiving medical attention.

**Learning Needs/**

**Educational Screening:** Instruct patient/guardian to contact school counselor, or other appropriate contact, if the child is experiencing difficulty in school or any other learning needs are listed.

**This client:**         **Requires Referral**         **Does not Require a Referral**

If a referral is required, please describe:

\_\_\_\_\_

Reviewed by: \_\_\_\_\_

**Primary Therapist's Signature**