OZARK GUIDANCE
CHILD QUESTIONNAIRE

Chart #_____

Date:_____

Child's Name: _____ 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:

Client	Relative *(list relationship)*	Client	Relative *(list relationship)*
___ 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: _____
_____

Other Occupants in the Home	**Age**	**Health**		
_____	____	__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