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New Client Form – Child/Adolescent
Date:

This questionnaire asks you to respond to a series of questions about you and your family. This type of information is very helpful in understanding your child. Please complete as best you can.

Child's Name _____ **Birth Date** _____ **Age** _____
School: _____ **Grade:** _____ **Teacher:** _____

Summarize briefly why you are seeking treatment at this time:

Did your child attend preschool? ___ Yes ___ No
Did your child repeat any grades? ___ Yes ___ No If yes, explain:

List any special education programs (i.e. IEP, Head Start):

Mother's Name _____ **Cell Phone:** _____ **Home Phone:** _____
Address _____

Is this your biological / adopted / step / foster child? Are you the child's legal guardian? ___ Yes ___ No

Father's Name _____ **Cell Phone:** _____ **Home Phone:** _____

Address (if different) _____

Is this your biological / adopted / step / foster child? Are you the child's legal guardian? ___ Yes ___ No

Siblings and/or others living in the home

Name Age Relationship (brother/ sister)

1. _____
2. _____
3. _____
4. _____

Referred by: _____

Pediatrician: _____ Phone Number: _____

CHILD'S BIRTH AND DEVELOPMENTAL HISTORY

Pregnancy length in months (or weeks) if known _____

Were any medications used during pregnancy? If yes, please specify. ___ yes ___ no

Did you smoke cigarettes during pregnancy? ___ yes ___ no If yes, how many per day? _____

Were there any complications during pregnancy or delivery? ___yes ___no If yes , please explain.

Child's condition at birth: ___poor ___good ___excellent

Place of birth: _____ Where raised: _____ Raised by whom?: _____

Developmental Milestones:

Child's approximate age when she/ he began: walking ___months talking (single words) ___months

talking (combining words) ___months toilet training: daytime ___years nighttime ___years

Overall, do you feel that your child developed at a ___slow, ___normal or ___rapid rate?

SOCIAL SKILLS

Compared to others of the same age, how does your child get along with other children?

___below average ___average ___above average

Compared to others of the same age, how does your child interact with adults?

___below average ___average ___above average

Who does your child prefer to play with? ___Family ___Alone ___Younger ___Same age ___Older Children___

MEDICAL HISTORY

Has your child had any of the following (please circle): speech problems, frequent ear infections, asthma, allergies, anemia, epilepsy, lead poisoning, seizures, heart problems, head injury, cerebral palsy, high fevers, other: __

Has your child had any serious illnesses, accidents, surgeries or broken bones? (Also include any poisonous substances your child has ingested): ___No ___Yes

Does your child have any sleeping difficulties? (trouble falling asleep, staying asleep, waking) ___Yes ___No

Does your child have any unusual eating patterns or habits? ___ Yes ___No

Is your child taking any ongoing medication?

Medication Purpose/Condition Dosage /Times per day How long on medication?

MOTHER'S HISTORY

Name _____ Birth Date _____

_____ Age _____

Highest grade completed _____ Highest degree _____

Have you experienced difficulties with reading, writing or math? If yes, explain. ___yes ___no

Any mental health problems for which you have received treatment?

If yes, please describe the problems and the treatment you received. ___yes ___no

Have you ever been told or thought yourself that you might have an attention deficit or be hyperactive?

___yes ___no

Any ongoing medical problems? ___yes ___no If yes, please specify.

Occupation _____ Current place of

employment _____

FATHER'S HISTORY

Name _____ Birth Date _____

Age _____

Highest grade completed _____ Highest degree _____

Any mental health problems for which you have received treatment? If yes, please describe the problems and the treatment you received. ___yes ___no

Have you ever been told or thought yourself that you might have an attention deficit or be hyperactive?

___yes ___no

Any ongoing medical problems? ___yes ___no If yes, please specify.

Occupation _____ Current place of employment _____

FAMILY MEDICAL HISTORY

Check any conditions present in child's biological family: (If checked, please explain)

Condition: Mother, Mother's Family (who?), Father, Father's Family (who?)

Birth Defects _____

Learning problems _____

Mental Retardation _____

Autism _____

ADHD/ ADD _____

Substance Abuse _____

Depression _____

Anxiety _____

Bipolar Disorder _____

Vision/Hearing disorder _____

Epilepsy/Seizures _____

Other learning, health or emotional problems: