Empower Recovery Services
Child/Adolescent history Questionnaire

Child's Name: _____Preferred Name:_____Today's Date_____

Age: _____ Gender: _____ Date of Birth_____ Race: _____

Your Name: _____ Relationship to Child: _____

Address: _____ Phone: _____ OK to leave Message _____

Emergency Contact: _____ Phone: _____

Biological Father's Name: _____ Age: _____

Biological Mother's Name: _____ Age: _____

Parents Marital Status: _____ Who has Legal Custody of the Child? _____

Child's Grade: _____ School Attending: _____

Were you referred to Empower (if yes who)? _____

What led you to seek our services? _____

_____

_____

_____

When did this begin? _____ How often this occurring? _____

Has the child ever been placed out of the home? _____

Family concerns: _____

Belief or religion practiced in the home? _____

Child's physical health issues and medications? _____

_____

Child have any legal issues or under probation? _____

_____

Past mental health diagnoses or services? _____

_____

_____

Psychiatric hospitalizations, when and where?_____

_____

Primary Household (who currently lives in house with child)

Name	Age	Relationship to child	Quality of relationship

Secondary Household

Name	Age	Relationship to child	Quality of relationship

Developmental Issues? _____

_____

_____

Trauma History (did the child experience any of the following:

Trauma history	Yes	No	Unknown	If yes, still occurring?
Physical abuse				
Witnessed domestic violence/abuse				
Physical neglect				

Emotional abuse				
Sexual abuse/molestation				
Community violence				
Bulling				
Child protection services involved with family				
Other traumatic experiences or losses				

Do you have any concerns over your child using alcohol or drugs? Yes_____ No _____

Substance	Past use	Current use
Alcohol		
Tobacco		
Caffeine		
Marijuana		
Methamphetamine/ Stimulants		
Heroin		
Cocaine		
Prescription drugs		
Synthetic drugs		
Other:		

Has your child ever participated in chemical dependency treatment programming? _____

Where and when? _____

_____

Does your child have any past suicide attempts? _____

If yes, when? _____

Any past self injurious behaviors (cutting or burning)? _____

If yes, when was last time? _____

Anything else that it would be helpful for us to know? _____

_____

_____

To be completed by child (10-18 years old)

1. Have you ever felt that you ought to cut down on your drinking or drug use?	Yes	No
2. Have people annoyed you by criticizing your drinking or drug use?	Yes	No
3. Have you ever felt bad or guilty about your drinking or drug use?	Yes	No
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	Yes	No
5. Have you used more chemicals at a time to get high?	Yes	No
6. Do you avoid family activities so you can use?	Yes	No
7. Do you use to change or improve your mood like when you feel sad or anxious?	Yes	No

To be completed by the child (12-18 years old)

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More then half the days	Nearly everyday
Feeling down, depressed, irritable, or hopeless				
Little interest or pleasure in doing things				
Trouble falling or staying asleep or sleeping too much				
Poor appetite or eating too much				
Feeling tired or having little energy				
Feeling bad about yourself. Or feeling that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, like schoolwork, reading, or watching TV				
Moving or speaking so slowly that other people could notice, or the opposite-being so fidgety or restless that you were moving around more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				

In the past year have you ever felt depressed or sad most days, even if you felt ok sometimes? Yes_____ No ____

If you checked off any of the problems, how difficult have these problems made it for you to do your work, take care of things at home, work, or get along with other people (circle one)

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Has there been a time in the past month when you had serious thoughts about ending your life? Yes_____ No_____

Have you ever, in your whole life, tried to kill yourself or made a suicide attempt? Yes_____ No_____