INSTITUTE FOR STRESS CONTROL
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QUESTIONNAIRE

Please complete and bring this
questionnaire with you to your first visit.

Patient's Name: _____ Date: _____
Date of Birth: _____ Gender (circle one): Male Female
Social Security Number of Minor Child: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Telephone No: _____Work Telephone No: _____
Should it be necessary to reach your child or adolescent, what number should be called?_____
May we leave a discreet message? _____Yes _____ No
List name of parents or guardian(s):

Name of Parent/Guardian: _____
Date of Birth: _____ Social Security Number: _____
Address (if different from Patient's): _____
Telephone Numbers: Home No: _____ Work No: _____
Cell No: _____ Other No: _____
Should it be necessary to reach this parent, what number should be called?: _____
May we leave a discreet message? _____

Name of Parent/Guardian: _____
Date of Birth: _____ Social Security Number: _____
Address (if different from Patient's): _____
Telephone Numbers: Home No: _____ Work No: _____
Cell No: _____ Other No: _____
Should it be necessary to reach this parent, what number should be called?: _____
May we leave a discreet message? _____

Please list person(s) responsible for bill if different from parent or guardian:
Name(s): _____
Date(s) of Birth: _____Social Security Number(s): _____
Address: _____
Telephone Numbers: Home No: _____ Work No_____

Specifically list the behavioral, emotional, or academic problems that concern you most and for which you are seeking help.

_____

_____

_____

_____

If you need more space, continue on the other side.

FAMILY INFORMATION

Name	Date of Birth	Address	Phone Numbers
Mother:	/ /		
Occupation:			
Level of Education			
Name	Date of Birth	Address	Phone Numbers
Father:	/ /		
Occupation			
Level of Education			
Name	Date of Birth	Address	Phone Numbers
Step-Mother:	/ /		
(*if applicable*)			
Occupation			
Level of Education			
Name	Date of Birth	Address	Phone Numbers
Step-Father:	/ /		
(*if applicable*)			
Occupation			
Level of Education			
Name			
Siblings/Step Siblings:	Date of Birth	Grade	Health Problems?
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		

IN THE CASE OF SEPARATION OR DIVORCE:

Date of Separation/Divorce: _____

Person(s) with Legal Custody: _____

Person with Residential Custody: _____

How has the patient adjusted to the separation/divorce?: _____

_____

Please describe your custody/visitation schedule. _____

_____

How would you describe the current relationship between the patient's biological parents? _____

_____

EDUCATIONAL HISTORY OF THE PATIENT

Patient's School School Address

Patient's Grade School Phone Number Teacher's Name

Is the patient currently attending school? Yes _____ No _____

If no, why not? _____

If yes, please note:
School: Public _____ Private _____ Other _____
Type of Program: Mainstream _____ Special Needs _____
Learning Disabled _____
Emotional Regulation Difficulties _____
Behavioral _____
Other _____
Eligibility: 504 ___ IEP ___
Type of Classroom: General Education _____ Self-contained _____
Has the patient repeated or skipped a grade: Yes _____ No _____

List schools attended:
School: _____ Grade: _____
School: _____ Grade: _____
School: _____ Grade: _____

Attendance issues: _____

Does your child receive these services at school? Social Work _____ Occupational Therapy_____
Speech_____ Physical Therapy_____
My child has a: Behavior Intervention Plan _____ Functional Behavior Assessment _____

CURRENT ACADEMIC PERFORMANCE

Rate the patient's academic performance in comparison to his/her classmates by circling the appropriate rating.

	Below Average		Average		Above Average
Reading:	1	2	3	4	5
Math:	1	2	3	4	5
Handwriting:	1	2	3	4	5
Overall:	1	2	3	4	5

Do you have any concerns about the quality of this child's school or teachers? No _____ Yes _____

If yes, describe: _____

MEDICAL INFORMATION

Patient's Family Physician: _____
Address: _____
_____
Telephone No: _____

Please list any current medications, vitamins, or herbal remedies that your child takes.
List dosage and prescribing physician:

Does he/she have any allergies (including allergies to medications)? _____ Yes _____ No
If yes, what:

Were there any problems during the pregnancy or birth? _____ Yes _____ No
If yes, describe:

Was this child born full term, after 9 months of pregnancy? _____ Yes _____ No
If born early, how early: _____ months
What was his/her weight at birth: _____

Did he/she have severe colic or feeding problems the first three months? ____ Yes ____ No
If yes, explain:

Do you feel your child developed normally the first two years of life? _____ Yes _____ No

When was your child's last physical exam? _____

Does he/she have any current or past medical problems? _____ Yes _____ No
If yes, describe: _____

Has he/she had any injuries such as broken bones, head injuries? _____ Yes _____ No
If yes, describe:

When was your child's last hearing and vision screening? _____

Has he/she had any surgeries? _____ Yes _____ No
If yes, describe:

Please note whether any *biological* relative of your child has been diagnosed with any of the following conditions. Next to any condition that is marked "yes," list the relative's relationship to your child. If there is any additional condition in your child's biological history that you think important, please list that condition.

Condition	No	Yes	Relationship(s) to Child
Alzheimer's Disease/Dementia			
Anxiety Disorder (including panic attacks)			
Attention Deficit/Hyperactivity Disorder			
Autism Spectrum Disorder			
Bipolar Disorder			
Depression			
Developmental Disability			
Learning disability			
Neurological disorder			
Obsessive Compulsive Disorder			
Process addiction (e.g., gambling)			
Seizure Disorder			
Substance abuse or addiction			
Suicide (list date & whether child was given info.)			
Tics (motor or vocal)			
Tourette's Disorder			

ADOPTION

Is your child adopted?_____ Yes _____ No

If yes, how old was your child when you received him/her? _____

Do you have a complete social/medical history of your child? _____

LIFESTYLE INFORMATION

Please list persons with whom your child lives and the nature of the relationship, e.g., mother, sister, uncle, etc.

If your child regularly spends full days, overnights, weekends, etc., in a place other than your home, list the lengths and hours of those times as well as the person taking care of your child.

List types and frequency of your child's physical exercise/activity:

On average, how much sleep does your child get each night? _____

Note child's usual wake time _____ and bed time _____

Does your child generally feel well rested? _____ Yes _____ No

How many times per week does your child eat in a restaurant or have "fast food"? _____

How many times per week does your child watch television or play video games? _____

How many hours per week does your child spend using a computer/tablet/cell phone? _____

Specify how many hours are related to school work: _____

How much time does your child spend texting, instant messaging, emailing, etc.?

List social activities, clubs, teams, etc., to which your child belongs.

Describe hobbies and/or pursuits that your child enjoys.

What is your child's/family's religion? _____
What is your child's/family's ethnicity? _____

Does your child regularly participate in any activity e.g., – church services – that you would view as being spiritually oriented? _____ Yes _____ No
Would you describe your family as having close family ties? _____ Yes _____ No
Feel free to add information._____

Does your family have a strong support system, i.e., close friends, extended family, etc.?
_____ Yes _____ No
Feel free to add information. _____

Does he/she smoke cigarettes, drink alcohol, or use any drugs? _____ Yes _____ No
If unsure or yes, describe: _____

Has he/she had any involvement with the police or the courts? _____ Yes _____ No
If yes, describe: _____

Are there any weapons kept in your home? _____ Yes _____ No
If yes, what are these: _____
Where are these kept? _____

Statement of Understanding

I understand that I am responsible for all fees related to my child's treatment. While an insurance plan may cover a portion of those fees, responsibility for payment rests with me since my child received those services.

_____
Signature of Parent or Custodial/Authorizing Parent

_____
Date