# CAREGIVER QUESTIONNAIRE

**CHILD'S NAME:** _____

**DATE OF BIRTH:** _____ **AGE:** _____

**RACE:** _____

**Who is filling out this form?** Name (Please print): _____

**Your signature and date:** _____

**Your phone number:** _____

**Relationship to child:**

- ☐ Legal Parent
- ☐ Foster Parent
- ☐ Other legal guardian
- ☐ GAL / CASA
- ☐ Therapist
- ☐ Law Enforcement
- ☐ CPS Caseworker
- ☐ DSS Treatment Worker
- ☐ DSS Foster Care Worker

1. Who lives with the child today?

| Name | Age | Gender (Male or Female) | Relationship |
|---|---|---|---|
| | | M F | |
| | | M F | |
| | | M F | |
| | | M F | |
| | | M F | |
| | | M F | |
| | | M F | |

Has the child recently changed homes? ☐ Yes ☐ No If YES, Who lived with the child before today?

| Name | Age | Gender (Male or Female) | Relationship |
|---|---|---|---|
| | | M F | |
| | | M F | |
| | | M F | |
| | | M F | |
| | | M F | |
| | | M F | |
| | | M F | |

2. Who is suspected of harming the child? (Give name, age)

3. How does the child know this person or persons?

4. How often did the child see this person or persons, and when was the last contact?

5. Tell us how you came to know there might be a problem. If the child said something to you, tell us what the child said, as close to the exact words as you can remember.

_____

_____

_____

_____

_____

_____

_____

6. What does the child know about coming here today? What was the child told?

7. Have previous interviews with the child been conducted?
If YES, describe:

☐ YES
☐ NO
☐ I DON'T KNOW

8. Do you have concerns about how the child is doing?
If YES, describe:

☐ YES
☐ NO
☐ I DON'T KNOW

9. Is the child receiving counseling or mental health services right now?
If YES, describe with whom and for what.

☐ YES
☐ NO
☐ I DON'T KNOW

10. Has there ever been a child abuse investigation involving this child before?
    If YES, describe:

☐ YES
☐ NO
☐ I DON'T KNOW

11. What else would you like us to know about the child or the situation?

_____

_____

_____

_____

_____

Thank you for answering these questions. The professionals who interview and / or examine the child will use this information to further guide the process.

Do you have questions or concerns that you would like to talk to the Victim Advocate about? Please write them below:

_____

_____

Are there any immediate or pressing needs with which the Victim Advocate can help you?

_____

_____

# Medical Questionnaire

Child's Name _____

Who is Filling Out This Form _____

## Past Medical History

1. Has your child had any of these medical conditions?

- ☐ Attention Deficit Disorder with Hyperactivity (ADHD)
- ☐ Developmental delay (please specify):_____
- ☐ Learning disability (please specify):_____
- ☐ Depression
- ☐ Anxiety
- ☐ Opposition Defiant Disorder (ODD)
- ☐ Autism Spectrum Disorder
- ☐ Seizures
- ☐ Other: _____

2. Has your child had any of these injuries?

- ☐ Burns
- ☐ Head injury
- ☐ Ingestion/Poisoning
- ☐ Broken Bones
- ☐ Stitches

How old was your child? _____

Please provide details of injury _____

3. Has your child ever been admitted to a hospital? ☐ Yes ☐ No

(a) How old was your child? _____

(b) What was the admission for? _____

(c) Name of hospital _____

4. Has your child ever had surgery or a medical procedure? ☐ Yes ☐ No

(a) How old was your child? _____

(b) What was the surgery or procedure for? _____

(c) Name of hospital _____

5. Is your child allergic to any foods or medicines? ☐ Yes ☐ No

Please list them: _____

6. Is your child taking any medicines now? ☐ Yes ☐ No

What is he or she taking? _____

_____

What is the medicine for? _____

_____

7. Who is your child's doctor? _____

8. How is your child doing in school? ☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

What is the name of your child's school?_____

What grade is your child in?_____

If your child is having difficulties at school, what is the problem? _____

_____

_____

## Family History

1. Do any of your child's caretakers have any of these problems? If so, who?

☐ Psychiatric or mental illness: _____

Is the caretaker receiving treatment? _____

☐ Drug or alcohol addiction: _____

Substances used: _____

☐ Past experience of physical or sexual abuse: _____

☐ Past involvement with law enforcement: _____

2. Has your family had any previous involvement with DSS? ☐ Yes ☐ No

Please explain: _____

_____

3. Has your child ever been around domestic violence? ☐ Yes ☐ No

## Review of Symptoms

1. Does your child have any problems with today:
   - ☐ Having difficulty sleeping
   - ☐ Clinging/whining
   - ☐ Hyperactive/impulsive
   - ☐ Fearful of being left alone
   - ☐ Sad or crying easily
   - ☐ Quiet or withdrawn
   - ☐ Angry outbursts
   - ☐ Hitting/biting siblings/friends
   - ☐ Difficulty making/keeping friends
   - ☐ Ran away from home
   - ☐ Have or had thoughts of hurting himself/herself
   - ☐ Tried to hurt himself/herself
   - ☐ Drinking alcohol
   - ☐ Sexualized behavior
   - ☐ Gang involvement
   - ☐ Using drugs
   - ☐ Started having sex
   - ☐ In trouble with the law
   - ☐ Other: _____

2. Does your child have any problems with today:
   - ☐ Pain when peeing
   - ☐ Blood in urine
   - ☐ Peeing frequently
   - ☐ Peeing in underwear (circle one): day night day & night
   - ☐ Pooping in underwear (circle one): day night day & night
   - ☐ Constipation
   - ☐ Urinary tract infections
   - ☐ Change in appetite
   - ☐ Frequent headaches

- ☐ Frequent stomachaches
- ☐ Genital itching
- ☐ Genital rash
- ☐ Genital pain or bleeding
- ☐ Anal itching
- ☐ Anal rash
- ☐ Anal pain or bleeding
- ☐ Vaginal or penile discharge
- ☐ Sexually transmitted infection (please specify): _____
- ☐ Other: _____

3. Does your child have any problems with today:
   - ☐ Eyes/Ears/Mouth/Nose (please specify):_____
   - ☐ Head/Neck (please specify):_____
   - ☐ Breathing/Lungs (please specify):_____
   - ☐ Heart (please specify):_____
   - ☐ Stomach/Abdomen (please specify):_____
   - ☐ Arms/Legs (please specify):_____
   - ☐ Genitals/Anus (please specify):_____