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QUESTIONNAIRE FOR PARENTS

Please complete this questionnaire as fully as possible before your child's first appointment. If you need additional space, please use the back of the page. When asked yes or no questions, please circle the appropriate answer.

Child's name _____

Child's date of birth _____ Age _____ ☐ Male ☐ Female

Address _____

_____

Phone Home _____ Other _____

Parent 1 name _____ Age _____

Work phone _____ Mobile phone _____

Parent 2 name _____ Age _____

Work phone _____ Mobile phone _____

Name of person completing this form _____

Relationship to child _____ Today's Date _____

Referred by _____

Address _____

Phone _____

May I thank the person referring you? _____

1. Please state the reason you are bringing your child for psychiatric evaluation. What is the problem(s)? _____

_____

_____

_____

When and how did the problem(s) begin? _____

_____

_____

_____

What has been done so far to try to alleviate the problem(s)? _____

_____

_____

_____

2. Psychiatric History

Has your child ever been hospitalized for psychiatric treatment? ☐ *Yes* ☐ *No*

If yes, please specify:

Dates of hospitalization: from _____ to _____ Name of hospital _____

Reason for hospitalization _____

Was the hospital treatment helpful? _____

Dates of hospitalization: from _____ to _____ Name of hospital _____

Reason for hospitalization _____

Was the hospital treatment helpful? _____

Has your child received any previous outpatient psychiatric treatment or counseling, or has he/she taken any medication for the treatment of emotional, behavioral, or learning problems? ☐ *Yes* ☐ *No* If yes, please specify below:

Dates of counseling: from _____ to _____ Name of therapist _____

Was treatment helpful? _____ Phone _____

Dates of counseling: from _____ to _____ Name of therapist _____

Was treatment helpful? _____ Phone _____

Dates of medication: from _____ to _____ Name of medication _____

Prescribing Doctor _____ City _____ Phone _____

Dosage _____ Was treatment helpful? _____

Dates of medication: from _____ to _____ Name of medication _____

Prescribing Doctor _____ City _____ Phone _____

Dosage _____ Was treatment helpful? _____

Other comments regarding past psychiatric treatment _____

_____

_____

_____

_____

<u>If your child has received previous treatment</u>, please bring with you to the first appointment the names and full addresses of the individuals, clinics, or hospitals where treatment has been provided.

3. Medical History

Has your child suffered from any of the following medical problems?

	Yes	No		Yes	No
Acute/Chronic Illness			Allergies		
Lead Ingestion			Hospitalization for Medical Illness		
Surgeries			Hearing Impairment		
Speech Problems			Vision Impairment		
Head Injury (e.g., concussions, loss of consciousness)			Kidney Problems		
Accidents/Fractures			Hormonal Problems		
Seizures			Memory Problems		
High Fever, Unknown Cause			Aggressive Behavior		
Heart Disease			Unusual Fears		
Asthma			Headbanging/Rocking		
Glaucoma			Discipline Problems		
Diabetes			Other medical problems (describe)		
Liver Problems					
Constipation					
Allergic Reactions to Medications					

If yes to any of the above, please provide details: _____

_____

_____

_____

_____

_____

Is your child currently taking any medication? (include over-the-counter medicine, such as cold or allergy preparations or any vitamins or herbal preparations)

Name of medication: _____ Dosage _____

Taken since _____ Why taking this medication _____

_____

Name of medication: _____ Dosage _____

Taken since _____ Why taking this medication _____

_____

If female, has your child started to have menstrual periods? ☐ *Yes* ☐ *No* If yes, when? _____

Date of last physical examination: _____

(Please ***bring a copy*** of most recent physical exam and any other pertinent medical records)

Your child's doctor _____

Address _____

_____

Phone _____

4. Developmental History

Was this a planned pregnancy? ☐ *Yes* ☐ *No*

Was the child adopted? ☐ *Yes* ☐ *No* If Yes, how old was the child at adoption?_____

Did mother have any medical problems or take any medications, or use drugs, alcohol, or cigarettes during pregnancy? ☐ *Yes* ☐ *No* If yes, please specify:

_____

Were there any medical complications associated with delivery (e.g., premature birth, caesarean section, forceps delivery, emergency delivery, meconium, etc.)?
☐ *Yes* ☐ *No* If yes, please describe: _____

Did your child have any medical problems as a newborn (e.g., low birth weight, yellow jaundice, breathing problems, neurological problems)?
☐ *Yes* ☐ *No* If yes, please describe: _____

Did your child have any medical problems in the first 3 months of life?
☐ *Yes* ☐ *No* If yes, please describe: _____

Your child's birth weight: _____

Describe your child's temperament as an infant: _____

_____

Was your child's motor development (e.g., age at which he/she sat up, rolled over, stood, walked, etc.) normal or delayed?

	Normal	Delayed	If delayed, please describe
Sat alone	☐	☐	_____
Crawled	☐	☐	_____
Stood alone	☐	☐	_____
Walked without holding	☐	☐	_____
Rode tricycle	☐	☐	_____

Was your child's speech and language development normal or delayed?

Normal ☐ Delayed ☐ If delayed, please describe:

At what age was your child toilet trained? Bladder _____ Bowel _____
Since being toilet trained, has your child had any problem with:

	Yes	No	If YES, until what age?
Wetting at night	☐	☐	_____
Wetting during the day	☐	☐	_____
Soiling at night	☐	☐	_____
Soiling during the day	☐	☐	_____

As an infant, toddler, and preschooler, did your child

have any problems with sleep? ☐ *Yes* ☐ *No* If yes, please describe:

_____

_____

have any eating problems? ☐ *Yes* ☐ *No* If yes, please describe:

_____

_____

have any unusual fears? ☐ *Yes* ☐ *No* If yes, please describe:

_____

_____

have more temper tantrums than other children?

☐ *Yes* ☐ *No* If yes, please describe:

_____

_____

have unusual problems in separating from parents?

☐ *Yes* ☐ *No* If yes, please describe:

_____

_____

How well does your child get along with other children?

_____

_____

_____

_____

_____

_____

5. Academic History

What grade in school is your child in? _____

Teacher's name _____

School name _____

Address _____

_____

Phone _____

Has your child ever been held back in school? ☐ *Yes* ☐ *No* If yes, when and why?

_____

Has he/she ever skipped a grade? ☐ *Yes* ☐ *No* If yes, when and why?

_____

Has he/she ever been in special education classes?

☐ *Yes* ☐ *No* If yes, when, what type of class, which subjects?

_____

What sort of grades does your child make in school?

_____

Have teachers or others ever told you that he /she had a learning disability?

☐ *Yes* ☐ *No* If yes, when? What were you told?

_____

Has your child ever had special educational or cognitive testing?

☐ *Yes* ☐ *No* If yes, please specify dates and results (and ***bring copies*** of reports to first visit):

_____

Has a teacher ever commented that your child is "hyperactive"?

☐ *Yes* ☐ *No* If yes, when? What were you told?

_____

Has a teacher ever commented on other behavioral or emotional problems?

☐ *Yes* ☐ *No* If yes, when? What were you told?

_____

6. Living Environment

Child's biological parents are

- ☐ married and living together
- ☐ unmarried and living together
- ☐ unmarried, not living together
- ☐ divorced
- ☐ separated
- ☐ parent deceased _____
- ☐ both parents deceased
- ☐ unknown
- ☐ other _____

If biological (or adoptive) parents are (or were) married, date married: _____

If biological (or adoptive) parents are divorced, date divorced: _____

Child lives with: _____

If child is adopted, age at adoption _____

Does child know of adoption? _____

Others in household

Sibling's name _____ Age _____ Sex: ☐ Male ☐ Female
Sibling's name _____ Age _____ Sex: ☐ Male ☐ Female
Sibling's name _____ Age _____ Sex: ☐ Male ☐ Female
Sibling's name _____ Age _____ Sex: ☐ Male ☐ Female

Others

Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____

Please list any other siblings not living in household

Sibling's name _____ Age _____ Sex: ☐ Male ☐ Female
Sibling's name _____ Age _____ Sex: ☐ Male ☐ Female
Sibling's name _____ Age _____ Sex: ☐ Male ☐ Female

Do any family/household members currently suffer from significant physical health problems?

☐ *Yes* ☐ *No* If yes, please describe:

_____

_____

_____

_____

Do any family/household members currently suffer from significant mental/emotional health problems? ☐ *Yes* ☐ *No* If yes, please describe:

_____

_____

_____

_____

Parent 1 educational attainment (check highest level obtained):

☐ did not graduate from high school
☐ high school graduate
☐ some college
☐ college graduate
☐ advanced college degree

Parent 1 occupation _____

Parent 2 educational attainment (check highest level obtained):

☐ did not graduate from high school
☐ high school graduate
☐ some college
☐ college graduate
☐ advanced college degree

Parent 2 occupation _____

Are there currently or have there been any significant marital problems?

☐ *Yes* ☐ *No* If yes, please describe:

_____

_____

_____

_____

Are there any other significant stresses currently affecting your family life (e.g., financial concerns, health problems, extended family concerns or conflicts, job problems, etc.)?

☐ *Yes* ☐ *No* If yes, please describe:

_____

_____

_____

_____

7. Family History

Has your child's biological father or have any of his family members had any of the following problems?

	Father	Father's mother	Father's father	Father's siblings	Other family
Depression					
Anxiety problems					
Obsessive-compulsive disorder					
Alcohol abuse					
Drug abuse					
Schizophrenia					
Hospitalized for psychiatric problem					
Learning difficulties as child					
Hyperactivity					
Mental retardation					
Other psychiatric problem					
Criminal behavior					
Unknown					

Has your child's biological mother or have any of her family members had any of the following problems?

	Mother	Mother's mother	Mother's father	Mother's siblings	Other family
Depression					
Anxiety problems					
Obsessive-compulsive disorder					
Alcohol abuse					
Drug abuse					
Schizophrenia					
Hospitalized for psychiatric problem					
Learning difficulties as child					
Hyperactivity					
Mental retardation					
Other psychiatric problem					
Criminal behavior					
Unknown					

8. Please provide any other information that you believe might be helpful in understanding the problems your child is having.

9. Addendum for adolescents

Has your child exhibited any self destructive behavior? ☐ *Yes* ☐ *No* Have you ever noticed any signs that the child may be hurting himself, such as scratch marks on his or her body? ☐ *Yes* ☐ *No* If yes, please describe.

Describe any concerns you have about your child's weight or eating habits.

Are you concerned about depression or withdrawal in your child? ☐ *Yes* ☐ *No*

Are you concerned about or suspicious of any substance use? ☐ *Yes* ☐ *No* If yes, please describe.

How does your child relate to other teenagers? How do you feel about their peer group?

How does your child spend his or her spare time?

With whom does your child share personal information?

Has your child been sexually active, pregnant, or responsible for a pregnancy?

Do you have concerns about your child's sexual orientation?

Has your child ever been involved with the police or juvenile justice authorities?