CHILD QUESTIONAIRE

DATE_____

CHILD'S NAME: _____
Last First Middle

AGE_____ BIRTHDAY____ /_____/_____

SCHOOL_____

GRADE_____

MOTHER'S NAME_____ FATHER'S NAME_____
ADDRESS (if different)_____ ADDRESS (if different)_____
_____ _____
_____ _____
WORK # ( )_____ WORK # ( )_____
Cell # ( )_____ Cell # ( )_____

PROBLEM CAUSING YOU TO SEEK TREATMENT/EVALUATION:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
NAME & ADDRESS OF CHILD's DOCTOR_____
_____
Current Medical problems and medications_____
_____
Drug Allergies_____
DATE OF LAST PHYSICAL EXAM_____

CURRENT PSYCHIATRIC MEDICATIONS_____
_____

PRIOR PSYCHIATRIC MEDICATIONS_____
_____

REVIEW OF SYSTEMS: For your child in each area, if they are not having any difficulties, please check "No Problems." If they are experiencing any of the symptoms listed, PLEASE CIRCLE THE ONES THAT APPLY, or explain any that may not be listed. If you have any questions about this, please ask your doctor.

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer.
Other:_____
_____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness.
Other:_____
_____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, snoring, racing heart, chest pains, swelling of feet or legs, pain in legs with walking.
Other:_____

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray.
Other:_____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other:_____
_____

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence.
Other:_____
_____

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain.
Other:_____

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other:_____
_____

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other:_____
_____

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions.
Other: _____
_____

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive.
Other: _____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas.
Other: _____

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV.
Other_____

CHILD'S CURRENT & PRIOR COUNSELING & EVALUATIONS:
Please list years, reasons for treatment, therapists and types of treatments.

_____
_____
_____
_____
_____
_____

PRIOR PSYCHIATRIC HOSPITALIZATION
Please list dates, reasons for admission and names of hospitals.

_____
_____
_____
_____
_____

MEDICAL HISTORY

Present height_____ Present weight_____
Present illness(es) for which child is being treated_____
_____
_____
Operations:_____
_____
Hospitalizations for illness(es) other than operations:_____
_____
If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

Childhood diseases (describe any complications):_____
_____
_____
_____
Head injuries_____with unconsciousness_____
without unconsciousness_____
Convulsions_____
with fever_____without fever_____
Coma_____
Meningitis or encephalitis_____
Immunization reactions_____
Persistent high fevers_____ Highest temperature ever recorded_____
Eye problems_____
Ear problems_____
Poisoning_____
Heart Disease_____
Fainting spells_____
Excessive Daytime Sleepiness_____
Sudden loss of consciousness_____

FAMILY HISTORY - MOTHER and mother's side of Family

Mother:
Age____ Age at time of pregnancy with patient____
Number of previous pregnancies____ Number of spontaneous____
abortions (miscarriages)____ Number of induced abortions____
Sterility problems (specify)_____
_____
School: Highest grade completed_____
Learning problems (specify)_____ Repeat Grade _____
Behavior problems (specify)_____
Medical problems (specify)_____

Have you or any of your blood relatives (not including patient and siblings) ever had problems similar to those your child has?
If so, describe_____
_____
_____

Have any of your blood relatives experienced or been diagnosed with any of the following (check all that apply; specify diagnosis and how related to patient):
Learning Disabilities (please specify)_____
_____
Anxiety Disorder_____
Autistic Spectrum Disorders_____
Depressive Disorders_____
Bipolar Disorders_____
Attention Deficit/Hyperactive Disorders_____
Autism, PDDNOS or Asperger's Syndrome_____
Schizophrenia_____
Obsessive Compulsive Disorders_____
Suicide attempts_____
Alcohol abuse_____
Drug abuse_____
Seizure Disorder_____
Psychiatric Hospitalization_____
Obesity_____Diabetes_____
Elevated Cholesterol/Triglycerides_____
Heart Disease/Cardiac Arrhythmia/Heart Attacks_____

Religious affiliation_____ Practicing?_____ Inactive?_____

FAMILY HISTORY – FATHER and Father's side of Family

Father:
Age____ Age at time of patient's conception____

Sterility problems (specify)_____
_____

School: Highest grade completed_____
Learning problems (specify)_____ Repeat Grade_____
Behavior problems (specify)_____
Medical problems (specify)_____

Have <u>you</u> or any of your blood relatives (not including patient and siblings) ever had problems similar to those your child has?
If so describe_____
_____
_____

Have any of your blood relatives experienced or been diagnosed with any of the following (check all that apply; specify diagnosis and how related to patient):
Learning Disabilities (please specify)_____
_____
Anxiety Disorder_____
Autistic Spectrum Disorders_____
Depressive Disorders_____
Bipolar Disorders_____
Schizophrenia_____
Attention Deficit/Hyperactive Disorders_____
Obsessive Compulsive Disorders_____
Suicide attempts_____
Alcohol abuse_____
Drug abuse_____
Seizure Disorder_____
Psychiatric Hospitalization_____
Obesity_____Diabetes_____
Elevated Cholesterol/Triglycerides_____
Heart Disease/Cardiac Arrhythmia/Heart Attacks_____
_____

Religious affiliation_____ Practicing?_____ Inactive?_

CHILD'S PRENATAL-PREGNANCY HISTORY

Complications:

Excessive vomiting_____ Hospitalization required_____
Excessive staining or blood loss_____ Threatened miscarriage_____
Infection(s) (specify)_____
Toxemia_____ Operation(s) (specify)_____
Other illness(s) (specify)_____
_____

Smoking during pregnancy___ Average number of cigarettes per day____
Alcohol consumption during pregnancy___ Describe, if beyond an occasional drink_____
Medications taken during pregnancy_____
X-ray studies during pregnancy_____
Pregnancy duration (# of weeks)_____

DELIVERY

Type of labor: Spontaneous____ Induced____
Forceps: High____ Mid____ Low____
Duration of labor Hours____
Type of delivery Vertex normal____ Breech____ Cesarean____
Birth weight_____
Appropriate for gestational age (AG)____
Small for gestational age (SGA)____

COMPLICATIONS

Cord around neck____ Cord presented first____ Hemorrhage____
Infant injured during delivery____ Other (specify)_____
_____
_____

POST-DELIVERY PERIOD (while in the hospital)

Respiration: Immediate____ Delayed____ (if so, how long)_____
Cry: Immediate____ Delayed____ (if so, how long)_____
Mucus accumulation____ Apgar score (if known)____ Jaundice____
Rh factor____ transfusion____ Cyanosis (turned blue)____ Incubator care____
Number of days in incubator____ Suck: Strong____ Weak____
Infection (specify):_____
Vomiting____ Diarrhea____ Birth defects (specify)_____
_____
Total number of days baby was in the hospital after the delivery_____

INFANCY-TODDLER PERIOD

Were any of the following present (to a significant degree) during the first few years of life? If so, describe:

Did not enjoy cuddling_____
Was not calmed by being held or stroked_____
Excessive spinnining_____
Colic_____
Did not babble_____
Did not smile when greeted by parents & other family members_____
Diminished sleep because of restlessness and easy arousal_____
Did not point to objects_____
Abnormal responses to environment stimuli: ie. sound, touch_____
Frequent headbanging_____
Constantly into everything or excessive restlessness _____
Excessive number of accidents compared to other children_____
Repetitive and stereotyped behavior_____
Overly interested in a limited number of topics: (Describe)_____

DEVELOPMENTAL MILESTONES

If you can recall, record the age at which your child reached the following developmental milestones. If you cannot recall, check item at right.

	Exact age	OR	early	at normal time	late
Smiled					
Sat without support					
Crawled					

	Exact age	OR	early	at normal time	late
Stood without support					
Walked without assistance					
Spoke first words besides :ma ma" and "da da"					
Said phrases					
Said sentences					
Bowel trained, day					
Bowel trained, night					
Bladder trained, day					
Bladder trained, night					
Rode tricycle					
Rode bicycle (without training wheels)					
Buttoned clothing					
Tied shoelaces					
Named colors					
Named coins					
Said alphabet in order					
Began to read					

COORDINATION

Rate your child on the following skills:

	Good	Average	Poor
Walking			
Running			
Throwing			
Catching			
Shoelace tying			
Buttoning			
Writing			
Athletic abilities			

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his or her age? If not, why not?

_____

_____

How would you rate your child's overall level of intelligence compared to other children?
Below average____ Average____ Above average____

SCHOOL

Rate your child's school experiences related to academic learning:

	Good	Average	Poor
Nursery school			
Kindergarten			
Current rade			

To the best of your knowledge, at what grade level is your child functioning:
reading:____ spelling____ arithmetic____

Has your child had to repeat a grade? If so, when?_____
Has your child had a Child Study team evaluation? If so when?_____
If classified, what is your Childs current classification?_____
Present class placement: Regular class____ Special class (if so, specify)_____

_____

Kinds of special therapy or remedial work your child is currently receiving_____

_____

Describe briefly any academic school problems_____

_____

Rate your child's school experience related to behavior:

	Good	**Average**	**Poor**
Nursery school			
Kindergarten			
Current grade			

Please describe any problems your child has had in school:

_____
_____
_____
_____
_____
_____

PEER RELATIONSHIPS

Does your child seek friendships with peers?____ If no, please describe your child's social interations._____
_____

Is your child sought by peers for friendship?____
Does your child play mostly with children his or her own age?____Younger?____Older?___

What does you child enjoy doing most?_____
_____
_____
_____

What does your child dislike doing most?_____
_____
_____

Does your child's teacher describe any of the following as significant classroom problems?
Please check all that apply:

- **Doesn't sit still in his or her seat____**
- **Frequently get up and walks around the classroom____**
- **Shouts out; doesn't wait to be called upon____**
- **Won't wait his or her turn____**
- **Does not cooperate well in group activities____**
- **Typically does better in a one-on-one relationship____**
- **Doesn't respect the rights of others____**
- **Doesn't pay attention during storytelling____**

Describe briefly any other classroom behavioral problems_____
_____
_____

TEMPERMENT: Describe your child temperament_____
_____
_____

Religious education:_____