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CHILD QUESTIONNAIRE

What do you want to see changed or improved? List the most serious problems you wish changed.

1. ____________________ 2. ____________________

3. ____________________ 4. ____________________

When did you first notice the problems? ____________________

What made you think something was wrong? ____________________

Have the problems gotten worse recently? If so, describe: ____________________

____

What do you think might be causing the problems? ____________________

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What ways have you and other family members tried to solve the problems?

Attempted Solutions	Level of Success: Never	Sometimes	Often	Always

How have the problems affected the family? Please mark severity in the appropriate box below.

NAME AND RELATIONSHIP TO PATIENT	1 (Little)	2	3	4	5	6	7	8	9	10 (Severely)

From the above evaluation, whom would you say is most affected by the problem? Why? ____________________

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How would you describe each family member's relation to these problems? ____________________

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Are you and spouse, partner, or others in agreement or disagreement on decisions about how to manage these problems? If yes, explain ____________________

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Does your child play successfully? Yes ___ No ___ With all ages ___ Older children ___ Younger children ___

What does your child enjoy doing the most? ____________________

What does your child dislike doing the most? ____________________

MOOD DISORDER SYMPTOMS CHECKLIST

IN THE PAST 6 MONTHS are you (if the patient) displaying, or has your child (if a family member) displayed the following behaviors in a way that you and/or significant others believe was inappropriate for the patient's age:

	None	Sometimes	Often	Always
Low energy, hard getting started, tired, everything takes effort				
Disappointed with self, feeling guilty or expecting punishment				
Critical of self, weaknesses, or mistakes, blames self frequently				
Losing interest and joy in people, frequently dissatisfied, bored				
Feeling edgy, inner tension, frequent dread or anguish				
More irritable, short tempered, verbally or physically aggressive				
Appears or feeling sad, low, gloomy, unable to brighten up				
Discouraged about the future, little to look forward to				
Pessimistic or negative thoughts, critical of self or others				
Feeling like a failure, looking back can only see failures				
Weary of life, saying they are better off dead, thoughts of suicide				
Crying for no reason, more than usual, want to cry but can't				
Worried they are unattractive, feels ugly and repulsive				
Has difficulty making or putting of decisions				
Change in concentration, reading ability				
Appetite change, loss or gain of weight, food tasteless				
Worried about physical problems, illnesses or health				
Not sleeping well, wakes up during night, early AM waking				
IF AGE APPROPRIATE – less or loss of interest in sex				
Persistently elevated, expansive or irritable mood				
Inflated self-esteem, grandiose thinking, arrogant, entitled				
More talkative or pressured, feeling like thoughts are racing				
Overly active and goal directed in activity				
Decreased need for sleep, still full of energy				

If you answered None to all the above questions, please skip to the next major section. Please make additional comments below, concerning the above behaviors: ______________________________

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ANXIETY SYMPTOMS CHECKLIST

IN THE PAST 6 MONTHS are you (if the patient) displaying, or has your child (if a family member) displayed the following behaviors in a way that you and/or significant others believe was inappropriate for the patient's age:

	None	Sometimes	Often	Always
Feeling of tension, keyed up, on edge, or restlessness				
Fidgeting, pacing, tremulous, fast breathing, pale, sweating				
Finds it difficult to control worrying				
Fearful of objects, people, places, or reluctant to be alone				
Overly worrying, fearful anticipation, refuses to be alone				
Difficulty fall or staying asleep, restless or unsatisfying sleep				
Fast heart beat, missing a beat, pain in chest, faint feeling				
Tightness in the chest, choking feeling, difficulty breathing				
Ears ringing, blurred vision, tingling feelings, headache				
Sudden, unexpected attack of above, with little or no cause				
Difficulty concentrating, or mind goes blank				

If you answer None to all the above questions, please skip to the next major section.

Has this disturbance caused significant problems at:

Home				
School				
With Friends				

Is your child taking any drugs or medicines that cause these symptoms? NO ___ If yes, name: ____________________

____

How old was your child when he/she began having the above symptoms? ________________

How often do these symptoms interfere with your child's activities? ________________

Do other family members have similar symptoms? ________________________

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Please make additional comments below concerning the above behaviors: ________________

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OBESSIONAL SYMPTOMS CHECKLIST

OBESSIONS are re-occurring THOUGHTS, WORRIES OR IMAGES that are unwanted, distasteful, inappropriate or intrusive. They are DIFFICULT TO STOP, and cause marked anxiety and distress. They significantly interfere with routine activities and social activities.

IN THE PAST 6 MONTHS are you (if the patient) displaying, or has your child (if a family member) displayed the following behaviors in a way that you and/or significant others believe was inappropriate for the patient's age:

	None	Sometimes	Often	Always
Excessive need for things to be "just right" or "perfect"				
Excessive concern about right and wrong or morality				
Excessive need to know or remember				
Excessive concern about germs or dirt or need to be clean				
Excessive need to touch				
Excessive need to save things others throw away				
Fears of harming his/herself or someone else				
Fears that something bad will happen unless he/she acts				
Fear of losing things, or taking special precautions not to lose				
Forbidden sexual ideas or impulses				
Recognizes the urges, thoughts are from his/her own mind				
Body twitching, unusual repetitive movements, tics				

If you have answered None to all of the above behaviors, skip to the next major section.

Has this disturbance caused significant problems at:

Home				
School				
With Friends				

Please make additional comments below concerning the above behaviors: ___________

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COMPULSIONS CHECKLIST

COMPULSIONS are re-occurring BEHAVIORS that attempt to relieve the marked anxiety and distress. They are unwanted, distasteful, or inappropriate. They are DIFFICULT TO STOP and significantly interfere with routine and social activities.

IN THE PAST 6 MONTHS are you (if the patient) displaying, or has your child (if a family member) displayed the following behaviors in a way that you and/or significant others believe was inappropriate for the patient's age:

	None	Sometimes	Often	Always
Excessive checking of things				
Excessive checking for mistakes				
Excessive reading and re-writing				
Need to repeat routine activities (in/out door, up/down stairs)				
Having to count or touch a certain number of times				
Having to rearrange things over and over again				
Excessive list making				
Excessive cleaning or washing				
Other compulsions not listed above (specify below)				

If you have answered None to all of the above behaviors, skip to the next major section.

Does the patient recognize that these obsessional thoughts and/or compulsive behaviors are excessive, unreasonable, or not normal? Yes ___ No ___

Has this disturbance caused significant problems at?

	None	Sometimes	Often	Always
Home				
School				
With Friends				

Was the patient taking any drugs or medicines just before these symptoms? No ___ If yes, name:

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Any type of upper respiratory infection before these symptoms? Yes ___ No ___

How old was your child when he/she began having obsessions & compulsions? ______________

How many hours a day does you child spend having obsessions & compulsions? ____________

Do other family members have obsessions & compulsions?______________________________

INATTENTION AND HYPERACTIVITY SYMPTOMS CHECKLIST

IN THE PAST 6 MONTHS are you (if the patient) displaying, or has your child (if a family member) displayed the following behaviors in a way that you and/or significant others believe was inappropriate for the patient's age:

	None	Sometimes	Often	Always
Difficulty attending to details or made careless mistakes				
Difficulty completing tasks at home or school				
Seems not to listen when spoken to directly				
Not follow instructions, finishing homework or chores				
Having difficulty getting organized at home, school play				
Avoiding or disliking things that require a lot of thinking through				
Being forgetful or losing things he/she needs or wants				
Easily distracted by little things, movements, noises				
Searches for intense stimulation, bored quickly				
Impatient, low frustration tolerance				
Enjoys little about school or learning				
Squirms in his/her seat, or fidgets with hands or feet				
Leaves their seat in class when not allowed				
Runs around or climbs when not allowed				
Has difficulty playing quietly				
Looks as if, or feels like he/she is "driven", "always on the go"				
Talks too much, and has difficulty stopping when asked				
Blurts out answers, interrupts or intrudes on others				
Has difficulty waiting for his/her turn				

If you have answered None to all of the above behaviors, skip to the next major section.

Has this disturbance caused significant problems at?

	None	Sometimes	Often	Always
Home				
School				
With Friends				

How old was your child when he/she began having obsessions & compulsions? ______________

Do there family members have similar problems? No ___ If yes, who? ____________________
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Please make additional comments below concerning the above behaviors: _________________
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OPPOSITIONAL DEFIANT SYMPTOMS CHECKLIST

IN THE PAST 6 MONTHS are you (if the patient) displaying, or has your child (if a family member) displayed the following behaviors in a way that you and/or significant others believe was inappropriate for the patient's age:

	None	Sometimes	Often	Always
Has temper tantrums				
Gets into arguments with adults				
Actively defies or refuses to comply with adult requests or rules				
Deliberately annoys people				
Blames others for his/her mistakes or behaviors				
Is touchy or easily annoyed by others				
Is angry and resentful toward others				
Is spiteful or vindictive				
Lies				

If you have answered None to all of the above behaviors, skip to the next major section.

Has this disturbance caused significant problems at?

	None	Sometimes	Often	Always
Home				
School				
With Friends				

How old was your child when he/she first began having these problems? ____________________

Do other family members have similar problems? No ___ If yes, who? ______________________

Please make additional comments below concerning the above behaviors: __________________

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CONDUCT DISORDER SYMPTTOMS CHECKLIST

IN THE PAST 6 MONTHS are you (if the patient) displaying, or has your child (if a family member) displayed the following behaviors in a way that you and/or significant others believe was inappropriate for the patient's age:

	None	Sometimes	Often	Always
Bullying, threatening or intimidating others				
Starting fights				
Used a weapon that could harm someone (e.g. knife, gun, club)				
Deliberately hurting someone				
Deliberately hurting animals				
Stolen things without the use of physical force				
Stolen thing with the use of physical force				
Forcing someone to have sex with him/her				
Deliberately starting fires to damage property				
Deliberately destroying things belonging to others				
Breaking into someone's house, car, or business				
Lying repeatedly to get things or tricking other people				
Stays out late at night against parental rules(starting before age 13)				
Running away from home at least twice				
Often skips school (starting before age 13)				

If you have answered None to all of the above behaviors, skip to the next major section.

Has this disturbance caused significant problems at?

	None	Sometimes	Often	Always
Home				
School				
With Friends				

How old was your child when he/she first began having these problems? ____________________

Do other family members have similar problems? No ___ If yes, who? ______________________

Please make additional comments below concerning the above behaviors: __________________

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DRUG & ALCOLHOL SYMPTOMS CHECKLIST

Are you (if the patient) displaying, or has your child (if a family member) displayed the following behaviors in a way that you and/or significant others believe was inappropriate for the patient's age:

	None	Sometimes	Often	Always
Smoking cigarettes				
Use of alcohol or drugs				
Acting different for no apparent reason				
Very annoyed whenever asked about drinking or drugging				
Increased amount of money being spent or missing from home				
Has tried to cut back on use of alcohol or drug				
Feeling guilty about alcohol or drug use				
Use creating problems in patient's relationships				
Failing to meet obligations and commitments				
Using substances in situations where there is a physical hazard				
Legal problems because of behavior while under the influence				
Leaving the home at odd times without permission				
Continued substance use despite recurrent interpersonal problem				
Spending less time at home, on previous interest, or old friends				
Legal problems because of drinking or using drugs				

If you have answered None to all of the above behaviors, skip to the next major section.

Has this disturbance caused significant problems at?

	None	Sometimes	Often	Always
Home				
School				
With Friends				

How old was your child when he/she first began having these problems? ________________

What substances have been used? ____

____

Please note other family members who have or have had similar problems:

Name	Relation to child	Type of use	Now/past	None	Sometimes	Often	Always

Please use the space below to make additional comments: ___________________________

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PAST PSYCHIATRIC TREATMENT

Have you (if the patient) or your child (if a family member) been treated before for the present problems, or any other nervous or psychiatric condition? If so, please answer below:

From To	# of Visits	Provider	Type of Treatment	Success -10 0 +10

If psychiatric mediations have been prescribed in past treatment, please circle the best of your ability, the class of medication used and the specific type prescribed if known.

- STIMULANTS: Ritalin (Methylphenidate), Dexedrine (amphetamines), Adderal and Cylert
- ALPHA RECEPTOR BLOCKERS: Catapres (clonidine), Tenex
- ANTIDEPRESSENTS: Tofranil (imipramine), Pamelor (nortipyline), Norpramine (desipramine), Prozac, Zoloft, Paxil, Luvox Wellbutrin, Effexor and others: ____________________
- MOOD STABLIZERS (Anticonvulsants): Depakote (valproic acid), Tegretol (carbamazepine), Dilantin, lithium (Eskalith, Lithobid, Lithonate) and others: ____________________
- ANXIOLYTICS: Xanax (alprazolam), Alivan (lorazepam), Klonopin (clonazepam), Valium (diazepam), Tanxene (cholrazepate), Buspar (buspirone) and others:____________________
- ANTIPSYCHOTICS: Haldol (haloperidol), Respidol (respiridone), Mellaril, Thorazine, and others: ____________________
- SLEEPING MEDICATION: Benedryl, Chlorohydrate, Halcion, Ambien and others: __________
- BETA BLOCKERS: Inderal (propranolol), Corgard, Temorin
- CALCIUM CHANNEL BLOCKERS: Verapamilm, Nifedipine, Dillazem

Name of Medication	Max. Daily Dose	Daily Dosage Times Per Day	# Days, Weeks Months taken	Date of Last Dose	Success -10 0 +10

Have you (if the patient) or has your child (if family member) ever made a suicide attempt or tried to harm self?
Yes___ No____ Total number of past suicide attempts: ____________________

If known, what feeling or experience is associated with thinking of killing or harming self? ____________
____

How similar is that experience to the present time? Circle: Not at all Somewhat Very

How angry and hostile have you been in the past month? 0------------------5------------------10

Have you (if the patient) or has your child (if a family member):

	Yes	No
Often done things impulsively, without thinking, before acting		
Ever seen anyone killed or seriously injured?		
Ever tried to kill or purposefully injure someone else?		
Ever killed or purposefully injured someone else?		
Ever been physically or sexually abused, raped or seriously injured by someone?		

Please use bottom and back of page for additional comments: ____________________
____

PATIENTS PAST MEDICAL HISTORY

Please list all major medical illnesses, injuries, accidents, surgery, and medical hospitalizations:

Year	Illness	Treatment	Result Poor	Fair	Good

List all current non-prescription medications: ______________________________

Current use of tobacco? Yes___ No ___ How much? ______________________________

If patient is female: Age at start of menstrual cycles: ______ Last menstrual cycle ____________

Have you (if patient) or your child (if a family member) ever seen the following behaviors?

	Yes	No
Keeping self from gaining any weight, being afraid of gaining weight or afraid of getting fat		
Seeing self as fat, or seeing their body as being unattractive		
Having ones weight strongly affected how they feel about themselves		
Having binge eating, or feeling out of control of the eating		
Making self throw up or exercising very hard		
Taking pills or laxatives to keep from gaining weight		

ALLERGIES

List all known: ____

____

DEVELOPMENTAL HISTORY

Prenatal care was provided during pregnancy? Yes ___ No ___ If yes, at what month? ______

Pregnancy: Full term?___ Premature?___ Late?___ Complications during pregnancy? _______

Were any medications, alcohol, drugs, or tobacco used? Yes ___ No ___ Circle appropriate response.

Were there any infections? Yes ___ No ___ Please specify: ___________________________

Delivery: Birth weight _________ Normal? ___ Difficult labor? ___ How many hours of labor___

Type of Delivery: Verlex(normal) ___ Breech ___ Forceps ___ Caesarian Section _____

Complications: Cord around neck ___ Cord first ___ Excessive bleeding ___ Injured during birth___

After Delivery: Difficulty breathing ___ Jaundice ___ Transfusions ___ Infections ___ Intensive Care ___

What description best fits you child as an infant?	Yes	No
Wanted to be picked up, reached out his/her arms		
Behaved as if shy or timid, slow to warm up		
Liked attention		
Was a friendly, easy-going baby		
Wanted to be left alone, upset when disturbed, difficult		
Seemed more interested in things than in people		
More stubborn than normal		
Mood changed frequently with ups and downs		

SOCIAL HISTORY

During the Past Year	Not at All	Some	A great Deal
Have you changed you place of residence?			
Has the composition of you household changed?			
Has the quality of you family life changed?			
Has any family member had major emotional problems?			
Has there been any serious injury or illness in your family?			
Have you had problems with your spouse or partner?			
Have you had problems with other family members besides the patient?			
Have there been problems with physical abuse or violence in the home?			
Has anyone changed where they work?			
Has anyone changed his or her type of work?			
Has any one been laid off or out of work?			
Has anyone's work become more stressful?			
Has anyone become dissatisfied with work or less productive at work?			
Has any family member had trouble or difficulties getting along at work or school?			
Has your family's standard of living changed?			
Has your family had a difficult time making ends meet?			
Has your family's income increased or decreased? Please circle your response.			
Has your family' expenses increased or decreased?			
Has your overall economic security changed in other ways?			
Have you or any other family members been in trouble with the law?			
Have you or any other family members had other types of legal problems?			

Currently employed? Mother ___ Father ___ Stepmother ___ Stepfather ___ Other ___

Type of work for each: Mother ________________ Father _________________Stepmother___
____________ Stepfather _______________ Other _________________

Church affiliation: Mother ______________ Father _________________Stepmother________
______ Stepfather _______________ Other __________________

Are each parent's family members aware of your child's problems? If not, explain: ___________
____

Are any public, city or state agencies involved with your family? No ___ If yes, please specify: _
____

Are any family members involved with any self-help or 12 Step Organizations? No ___ If yes, please specify: ____

How much stress is your family under? (Circle) None Mild Moderate Severe Very Severe

How much support do you receive from others in dealing with this stress? None Some Good Very Good

Who is the family's principal emotional support? ______________________________________

In what ways? ____

Who doesn't give support but should? ___________________ Why? _____________________
____

What other information do you want me to have about your child's history and current issues?

If you and your child's other birth parent are divorced, please describe the legal arrangements regarding visitation, custody, etc. NOTE: This office will require a copy of all legal documents regarding parent's legal rights in order to be able to ethically respond to requests for treatment, requests for records, etc. This must be received before treatment with your child begins.