

Pediatric Behavioral Health
Initial Questionnaire

Directions: This form is very important to help with the interview and evaluation process. Not all questions apply to all families; just answer questions as best as they apply to your family. Your answers will help us to better address your child's needs and to better understand your child. It takes about 15-20 minutes to complete. Thank You.

Demographic Information: Today's Date: _____

Child's Name: _____ Child's Sex: Male Female

Child's Date of Birth: _____ Child's Age: _____

Child's School: _____ Child's Grade: _____

Child's Race: _____ Height: _____ Weight: _____

Biological Mother Information:
Name: _____ Age: _____

Occupation: _____ Education: _____

Marital Status: _____ Date of Marriage: _____

Biological Father Information:
Name: _____ Age: _____

Occupation: _____ Education: _____

Marital Status: _____ Date of Marriage: _____

Step-Mother Information:
Name: _____ Age: _____

Occupation: _____ Education: _____

Step-Father Information:
Name: _____ Age: _____

Occupation: _____ Education: _____

Sibling Information:

Name: _____	Age: _____	Full	Half	Step	Adopted
Name: _____	Age: _____	Full	Half	Step	Adopted
Name: _____	Age: _____	Full	Half	Step	Adopted
Name: _____	Age: _____	Full	Half	Step	Adopted

List all people with whom the child lives: _____

Presenting Problem / Referral Question:

Please list the three biggest reasons (or problems) for which you are seeking help for your child:

1. _____
2. _____
3. _____

Problem History:

1. Approximately how old was your child when you first noticed your child's problem? What did the problem look like then?

2. How has your child's problem changed throughout his/her growth?

3. What is your child's attitude toward his/her problems?

4. Has your child had any other behavioral or emotional problems in the past (even if they are not affecting him/her now)? Describe.

5. Previous therapy experiences of your child (include family, school, therapy and psychiatric medications).

Therapist's Name	Therapy Dates	Clinic Name and Phone #	Reason for Therapy	Effectiveness of Therapy
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- a. _____
- b. _____
- c. _____

6. Has your child ever talked about hurting or killing him/herself or another person? Describe.

7. Has your child ever used or abused medication, illegal drugs, or alcohol? Describe.

8. Who referred you for psychological services? _____

9. Do you agree with this referral? YES NO Mixed Feelings

Family Background

1. List marriages of biological MOTHER (past and present):

Spouse's Name	Marriage Date	Children's Names	Divorce Date	Reason for Divorce
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. List marriages of biological Father (past and present):

Spouse's Name	Marriage Date	Children's Names	Divorce Date	Reason for Divorce
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

3. Please indicate if the following have occurred in the family:

	Date(s)	Description / Comments
Divorce	_____	_____
Separation	_____	_____
Marital Problems	_____	_____
Domestic Violence	_____	_____
Excessive Conflict	_____	_____
Death of Parent	_____	_____
Death of Child	_____	_____
Death of Grandparent	_____	_____
Alcohol Abuse by Parent	_____	_____
Drug Abuse by Parent	_____	_____
Move to New Home	_____	_____
Physical or Sexual Abuse	_____	_____
Illness of Family Member	_____	_____
Other Changes	_____	_____

4. How is discipline handled in the family?

5. Who is most responsible for discipline? Mother Father Both

6. Describe your relationships with the following extended family members.

- | | | | | |
|-----------------------|-----------|------|------|------|
| a. Father's Parents: | Excellent | Good | Fair | Poor |
| b. Mother's Parents: | Excellent | Good | Fair | Poor |
| c. Father's Siblings: | Excellent | Good | Fair | Poor |
| d. Mothers' Siblings: | Excellent | Good | Fair | Poor |
| e. Child's Cousins: | Excellent | Good | Fair | Poor |
| f. Other _____: | Excellent | Good | Fair | Poor |

7. Family Religion: _____

Developmental History:

1. How did the parents feel when they found out that the mother was pregnant? Was the child planned?
2. Please circle all that occurred during the mother's pregnancy with this child:

a. Smoking (# packs / day _____)	g. Physical Abuse of Mother
b. Drinking Alcohol (# drinks / day _____)	h. Extreme stress on Mother
c. Marijuana Use	i. Major Illness of Mother (Name: _____)
d. Cocaine / Crack Use	j. Major Injury of Mother (Name: _____)
e. LSD Use	k. Regular prenatal care
f. Other Street Drug Use (Name: _____)	l. Premature Labor
3. Describe significant events or complications about the pregnancy:
4. Describe complications during child's delivery?

5. Birth History:

- a. Child's Weight at Birth: _____
- b. Premature Birth? NO YES (# of weeks gestation _____)
- c. Problems / Illnesses immediately after birth: _____
- d. Admission to hospital / neonatal ICU: NO YES

6. At what age did your child:

- a. Sit: _____
- b. Crawl: _____
- c. Walk: _____
- d. Say First Word: _____
- e. Say Two Word Sentences: _____
- f. Toilet Trained: _____

Would you say that your child developed faster, slower, or at about the same rate as other children? _____

7. Circle all that apply to your child as a baby:

- a. Cuddly
- b. Irritable
- c. Cried A lot
- d. Slow to Warm Up
- e. Curious
- f. Active
- g. Good Sleeper
- h. Tense / "On Edge"
- i. Difficult to Soothe
- j. Withdrawn
- k. Friendly
- l. Afraid of strangers
- m. easy to put on a schedule
- n. Easily startled / Overreactive

Medical History:

1. Current Medications that your child is taking:

Name	Dose	Times Per Day	Reason
a. _____			
b. _____			
c. _____			

2. Past medications that your child has taken for behavior or psychological problems (list name only):

- a. _____ b. _____ c. _____

3. Are your child's immunizations up to date? YES NO

(If not, what one's are not? _____)

4. Allergies:

Allergy	Typical Reaction
a.	_____
b.	_____
c.	_____

5. Serious and/or life-threatening illnesses:

Date	Illness	Consequences
a.	_____	_____
b.	_____	_____
c.	_____	_____

6. Major Injuries:

Date	Injury	Consequences
a.	_____	_____
b.	_____	_____
c.	_____	_____

7. Major Hospitalizations:

Dates	Reason for Hospitalization
a.	_____
b.	_____
c.	_____

8. Surgeries:

Date	# Days Hospitalized	Reason for Surgery
a.	_____	_____
b.	_____	_____
c.	_____	_____

9. Exposure to Poisons or Toxic Substances:

	Date	Substance	How Exposed (i.e. Drank)	Effect on Child
a.	_____	_____	_____	_____
b.	_____	_____	_____	_____
c.	_____	_____	_____	_____

10. Does anyone in the child's immediate or extended family have the following illnesses or problems? Include brothers, sisters, father, mother, grandparents, aunts, uncles, cousins.

<u>Illness</u>	<u>Circle Y or N</u>		<u>Relationship to the Child (i.e., aunt, father, etc.)</u>
Depression	Y	N	_____
Manic Depression	Y	N	_____
Nervous Breakdown	Y	N	_____
Psychiatric Hospitalization	Y	N	_____
Delayed Reading	Y	N	_____
Delayed Speech	Y	N	_____
Mental Retardation	Y	N	_____
Attention Problems	Y	N	_____
Hyperactivity	Y	N	_____
Heavy Drinking	Y	N	_____
Drug Abuse	Y	N	_____
Suicide	Y	N	_____
Stealing	Y	N	_____
School Phobia	Y	N	_____
Epilepsy	Y	N	_____
Felony Conviction	Y	N	_____

Illness	Circle Y or N	Relationship to the Child (i.e., aunt, father, etc.)
Anxiety Disorder	Y N	_____
Schizophrenia / Psychosis	Y N	_____
Autism / Asperger's Disorder	Y N	_____
Eating Disorder	Y N	_____
Insomnia	Y N	_____
Any Genetic Disorder	Y N	_____
Other _____	Y N	_____

Social History:

1. Check ALL which describe your child socially:

- _____ Other children seek him/her out for play
- _____ S/he seeks out other children for play
- _____ S/he prefers to play alone
- _____ Lots of children like him/her, AND few children dislike him/her
- _____ Lots of children like him/her, BUT lots of children don't like him/her
- _____ Other children pretty much ignore my child
- _____ My child fights a lot with other children
- _____ My child often plays cooperatively with other children

2. How many friends does your child have around his home? _____

3. How much time does your child play with those friends per day? _____

4. How many friends does your child have at school? _____

5. How much time does your child play with those friends per day? _____

6. Does your child have a best friend? YES NO

If yes, what is the best friend's first name _____

7. How does your child get along with non-parent adults (check all that apply)?

- _____ Friendly
- _____ Cooperative
- _____ Disobedient
- _____ Disrespectful
- _____ Better behaved than with parents
- _____ Adults like my child
- _____ Obedient
- _____ Other _____

8. How does your child get along with teachers / coaches?

- | | |
|----------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Friendly | <input type="checkbox"/> Better behaved than with parents |
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Adults like my child |
| <input type="checkbox"/> Disobedient | <input type="checkbox"/> Obedient |
| <input type="checkbox"/> Disrespectful | <input type="checkbox"/> Other _____ |

9. How does your child get along with brothers and sisters?

- | | |
|--------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Likes them | <input type="checkbox"/> Protective of them |
| <input type="checkbox"/> They like him/her | <input type="checkbox"/> Aggressive / Fights |
| <input type="checkbox"/> Jealous | <input type="checkbox"/> Won't share things |
| <input type="checkbox"/> Ignores them | <input type="checkbox"/> Wants to be babied |
| <input type="checkbox"/> Other _____ | |

10. Has your child ever had a sexual relationship? YES NO
If yes, describe

11. Has your child ever been arrested, accused, or convicted of a crime? YES NO
If yes, what crimes?

12. Has your child been sexually abused? YES NO
If yes, Describe

13. Has your child been physically abused? YES NO
If yes, Describe

14. Has your child been emotionally abused? YES NO
If yes, Describe

Academic History:

1. Has your child even been in nursery or day care? YES NO
If yes, what ages? _____

2. At what age did your child start kindergarten? _____

3. At what age did your child start first grade? _____

4. Has your child ever been held back a grade? YES NO
If so, what grade(s)? _____

5. Previous Psychological or Educational Testing of your child

	Date	School / Clinic	Reason for Testing	Findings
a.	_____	_____	_____	_____
d.	_____	_____	_____	_____
e.	_____	_____	_____	_____

6. Does your child have an IEP (Individual Education Plan)? YES NO
If yes, Describe

7. Is your child in any of the following class placements?

_____ Resource Room (What subjects? _____)

_____ Gifted Class (What subjects? _____)

_____ Special Education Class

_____ Emotionally Handicapped (EH or BEH) Class

8. What are your child's grades?

9. What school subject does your child like most? _____

10. What school subject does your child like least? _____

11. How is your child's behavior in school (check all that apply)?

- | | |
|------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Disobedient | <input type="checkbox"/> Overactive |
| <input type="checkbox"/> Worried / tense | <input type="checkbox"/> Withdrawn / shy |
| <input type="checkbox"/> Not liked by children | <input type="checkbox"/> Popular |
| <input type="checkbox"/> Not liked by teachers | <input type="checkbox"/> Class clown |
| <input type="checkbox"/> Other _____ | _____ |

12. List changes in your child's school setting during his/her life. Why were these changes made? How did your child react?

13. Have any of the following happened to your child at school (check all that apply)?

- Suspended
- Expelled
- Special conference for behavior problems
- Switched classes because of problems

Please provide any additional information that you think would be helpful.