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Psychosocial and Developmental Information

Child and Adolescent Program

This information will be used to develop a treatment program for your child. We realize the questionnaire is lengthy and will require a great deal of work to complete. However, it is an important investment of your time and energy in your child's diagnostic and treatment planning. Your careful, honest and complete attention to all details is greatly appreciated. If you have difficulty in remembering some of the information, simply write in "Cannot Remember," but only if you have no recollection at all. Any memories may help. If a question is not applicable to your child, write in "NA."

GENERAL INFORMATION •

1)Patient/Child Name: _____ Age: _____

2) Birthday:_____ Sex: _____ Home Phone _____ Cell Phone:_____

3) Home Address: _____ City: _____

4) Biological Father: _____ Age: _____ Birthdate: _____

Education: _____ Date Married to Biological Mother: _____

Employment: _____ Office Phone: _____

5) Biological Mother: _____ Age: _____ Birthdate: _____

Education: _____

Employment: _____ Contact Number: _____

6) Who is the legal guardian of child? _____

Person to be notified in an emergency: _____

Phone Number: _____ Relationship_____

7) School: _____ Phone: _____

Grade: _____ Teacher: _____

Special Education: ☐ Yes ☐ No

8) Child's Pediatrician/Family Physician: _____Phone: _____

All Current Medication(s) (List Dose and Frequency): _____

_____

_____

Allergies? (Include Medications, Plants and Animals) _____
_____

May we contact your child's Pediatrician/Physician to obtain further history: Yes☐ No☐
Signature _____ Date_____

May we contact your child's Psychiatrist to obtain further history: Yes☐ No ☐
Signature _____ Date_____

Any other mental Health Providers Currently involved?: _____

_____

_____

Referral Information:

Who referred you? _____ Profession: _____

Reason for brining the child in: _____

_____

Problems has been going on for (i.e. weeks, mouths, etc.): _____

If adopted please provide information about biological parents if available: _____

_____

_____

MEDICAL HISTORY

CHILD'S PREGNANCY

Any Illness? _____
Duration? (weeks) _____
Any Medications? _____
Any use of drugs/alcohol? _____

DELIVERY _____
Any complication? _____
Natural/C-Section _____
Birth Weight _____

DEVELOPMENTAL MILESTONES

Did child pass milestones on time? _____
How was child's Language Development? _____
(Talked on time or was delayed) _____
Is your child Clumsy? Does he, have Problems _____
with Fine or Gross motor-skills? _____

Any current illness or Medical problem? _____

Has child had a problem with bedwetting? _____

Does child bruise or bleed easily? _____
Has child had an abnormal
heart exam or EKG? _____
Has your child ever had seizures? _____
Does your child have frequent ear infection? _____
Any handicapping condition? (deafness, etc) _____
Any activity limitations? _____
Any Surgeries? _____
Any serious illness in the past? _____
Had a concussion or head injury? _____
Other serious injury (Broken Bone)? _____

FAMILY HISTORY

Bipolar disorder _____
Schizophrenia _____
ADHD _____
Suicide _____
Anxiety/depression _____
Drug/alcohol abuse _____
Tics/ Tourette's _____
Learning Disability _____
Autism/Asperger's _____
Other Mental Illness _____
_____

Diabetes _____
Hypertension _____
Asthma _____
Arthritis _____
Cholesterol _____
Seizures _____
Migraine Headaches _____
Other medical Problems _____
_____
_____
_____

DEPRESSION

Please check items if applicable to the Patient:	Yes	No
Depressed mood or irritable mood	____	____
Irritable	____	____
Pouts and sulks Cries easily, tearful	____	____
Sullen	____	____
Easily frustrated	____	____
Angers easily	____	____
Hostile to others	____	____
Temper outbursts	____	____
Decreased interest or pleasure in activities	____	____
Enjoys new situations	____	____
Spends more time with adults	____	____
Decreased or increased in appetite		
Eats poorly	____	____
Failure to make expected weight gain		
Overeats, cravings for sweats, starch, etc	____	____
Obesity, difficulties losing weight	____	____
Difficulties with sleep pattern	____	____
Sleeps through the night	____	____
Awakens in morning earlier than necessary	____	____
Difficulties falling asleep	____	____
Wakes up in the middle of the night	____	____
Falls asleep well	____	____
Psychomotor agitation or retardation	____	____
Moves slowly	____	____
Demonstrates slow speech	____	____
Talks a 1ot	____	____
Fatigue, loss of energy	____	____
Tires easily	____	____
Feelings of worthlessness or excessive or inappropriate guilt	____	____
Self-critical	____	____
Diminished ability to think or concentrate, indecisiveness	____	____
Problems with concentration and attention	____	____
Forgetful	____	____

Unable to make up his/her mind	____	____
Refuses to go to school	____	____
Leaves school- "hooking"	____	____
Recurrent thoughts, of death, suicidal ideation	____	____
Feelings of hopelessness	____	____
Feelings of helplessness	____	____
Self-cutting	____	____
Talks about fear of parents dying	____	____
Suicidal thoughts	____	____
Somatic Complains		
Complaints of headaches	____	____
Bowel problems	____	____
Nausea or vomiting	____	____
Complains of stomachs	____	____

Additional Comments _____
_____
_____

MANIA CHECKLIST

	Yes	No
Abnormally and persistently elevated, expansive, or irritably mood	___	____
Inflated self-esteem or grandiosity	____	____
Flight of ideas or racing thoughts	____	____
Increased in goal directed activity (work, social, sex)	____	____
Excessive involvement in pleasurable activities (Not videogames)	____	____
Increased need for sleep	____	____
More talkative than usual or pressure to keep talking distractibility	____	____
Psychomotor agitation, fidgety, hyperactivity	____	____

Additional Comments:
_____
_____
_____

ANXIETY

	YES	NO
SOCIAL INTERACTIONS OR PERFORMANCE		
Has fear of and/or avoids participating in group activities, going to a party or social 'event, talking with a stranger, talking on the phone	_____	_____
Reluctant or refuses to talk in front of a group, write in front of other people, eat in public, Use a public bathroom, change into gym clothes or bathing suit with Others present	_____	_____
Persistent fear of social or performance situations in which you Are exposed to unfamiliar people or to scrutiny by others.	_____	_____
Fear that you may act in humiliating or embarrassing way	_____	_____
The social situation produces anxiety	_____	_____
SEPARATION		
Worry about harm happening to attachment figures, self, including the fear of dying	_____	_____
Distress when separation occurs or is anticipated	_____	_____
Complains of physical symptoms when separation occur or is anticipated.	_____	_____
Fear or reluctance to be alone	_____	_____
Refusal to go to school	_____	_____
Refusal to go to sleep alone and. Nightmares with a separation theme	_____	_____
Refusal to sleep away from home	_____	_____
Clings to parent, or follow parent around the house	_____	_____
GENERALIZED		
Excessive worry about everyday or real-life problems	_____	_____
Restlessness or feeling on edge	_____	_____
Easily fatigued	_____	_____
Difficulty concentrating or mind going blank	_____	_____
Irritability	_____	_____
Muscle tension or nonspecific tension	_____	_____
Sleep disturbance,	_____	_____

OTHER PHOBIA: Specify,

_____
_____
_____

ACUTE PHYSICAL SIGNS & SYMPTOMS

Panic Attacks, Please described triggers, duration and how many in the last week/month.

_____

_____

	YES	NO
Blushing	_____	_____
Feels paralyzed	_____	_____
Trembling or shaking	_____	_____
Feels dizzy, unsteady, lightheaded or going to pass out	_____	_____
Palpitations or pounding heart	_____	_____
Difficult breathing (sensation of shortness of breath, smothering or choking)	_____	_____
Chills or hot flashes	_____	_____
Sweating	_____	_____
Feels sick to stomach, nausea or abdominal distress	_____	_____
Recurrent urge to go to the bathroom	_____	_____
Chest pain or discomfort	_____	_____
Paresthesias (numbness or tingling sensation in finger or toes)	_____	_____

AGORAPBOBIA

Are you worried about being in places or situations from which escape might be difficult or embarrassing or in which help may not be available in the event of having an unexpected panic attack. (Crowd place, bridge, planes)	_____	_____
Are the situations avoided or mark with distress.	_____	_____

TRAUMA

Being exposed to a traumatic event	_____	_____
Persistently experienced the traumatic event	_____	_____
Attempts to avoid stimuli associated with the trauma	_____	_____

Additional Comments:

_____

_____

_____

_____

O B S E S S I O N S

Please mark all that apply,

_____**Contamination:** Concerns with: dirt, germs, certain illnesses, bodily waste or secretions, environment contaminants, household items, animals/insects, sticky substances, getting ill because of contaminant, getting others ill.

_____**Aggressive:** Fear-Might harm self, others. Fear harm will come to self, others. Violent or horrific images

_____**Sexual**: Forbidden or perverse sexual thoughts, images or impulses: involving homosexuality.

_____**Hoarding/Saving:** Fear of losing things.

_____**Magical Thoughts/Superstitious:** Lucky/unlucky numbers, colors, words

_____**Somatic:** Excessive concern with body part or aspect or appearance

_____**Religious:** Excessive concern or fear of offending religious objects (God), with right/wrong morality

_____**Miscellaneous**: need to know or remember, Fear of not saying just the right thing, Intrusive sounds, words, music, or numbers

Additional Comments:

_____

_____

COMPULSIONS

_____**Cleaning/Washing:** Excessive or ritualized hand washing, showering, bathing, tooth brushing, grooming or toilet routine

_____**Checking**: Checking locks, toys, school books/items, getting washed, dressed, or undressed, did not/will not harm self or others, nothing terrible did/will happen, did not make mistake

_____**Repeating Rituals:** Rereading, erasing, or rewriting, Need to repeat routine activities.

_____**Counting:** Objects, certain numbers, words, etc.

_____**Ordering/Arranging**: Need for symmetry. /evening up.

_____**Hoarding/Saving**: Difficulty throwing things away

_____**Excessive Games/Superstitious Behavior:** behavior, such as stepping over certain spots on a floor, touching an object/self-certain number of times as a routine game to avoid something bad from happening.

_____**Rituals Involving Other Persons**: asking a parent to repeatedly answer the same question.

_____**Miscellaneous**: Need to tell, ask or confess, Ritualized eating behaviors, Ritualized eating behaviors, Excessive list making, Need to touch, tap, rub, Need to do things (e.g., touch or arrange until it feels just right), Trichotillomania (hair-pulling), self-mutilating behaviors

Additional Comments:

_____

_____

_____

_____

ADHD

Symptoms of Inattention

- ☐ Often fails to pay close attention to details or mistakes in schoolwork, work or other activities
- ☐ Often has difficulty maintaining focus on tasks or play activity
- ☐ Often does not seem to listen when spoken to directly
- ☐ Often does not follow through on instructions and fails to finish schoolwork, chores, or other responsibilities (not due to oppositional behavior or failure to understand instructions)
    - o Often cannot remember
    - o Dislikes school
- ☐ Often has difficulty organizing tasks and activities
- ☐ Often avoids, dislikes, or is reluctant to take part in activities that require continuous mental effort, such as schoolwork or homework
- ☐ Often loses things needed for tasks or activities, such as toys, assignments, books or tools
- ☐ Is often easily distracted by extraneous stimuli
- ☐ Is often forgetful in daily activities

In your opinion the severity of *Inattention* is:

None 1 2 3 4 5 Severe

Symptoms of Hyperactivity

- ☐ Often fidgets with hands or feet or squirms in seat
- ☐ Often runs around or climbs excessively in situations in which it is not appropriate
- ☐ Often leaves seat in classroom or other situations in which staying seated is expected
- ☐ Often has difficulty playing or engaging in leisure activities quietly
- ☐ Is often “on the go” or often acts as if “driven by a motor"
- ☐ Often talks excessively
- ☐ Often has trouble in school

In your opinion the severity of *Hyperactivity* is:

None 1 2 3 4 5 Severe

Symptoms of Impulsivity

- ☐ Often blurts out answers before questions have been completed
- ☐ Often has difficulty waiting for turn
- ☐ Often interrupts or intrudes on others(e.g., butting into conversations or games)
- ☐ Often tears up toys
- ☐ Has trouble keeping friends

In your opinion the severity of *Impulsivity* is:

None 1 2 3 4 5 Severe

Disruptive Behaviors

Symptoms of Opposition Defiant Behavior

- ☐ Often oppositional
- ☐ Often argumentative
- ☐ Often angry and resentful
- ☐ Often spiteful or vindictive
- ☐ Often touchy or easily annoyed by others
- ☐ Often loses temper
- ☐ Often refuses to comply
- ☐ Often annoys people
- ☐ Often blames other for his/her mistakes

Conduct Problems

Aggression

- ☐ Often bullies, threatens, or intimidate others
- ☐ Often initiates physical fights
- ☐ Has us a weapon that can cause serious physical harm to others
- ☐ Has been physically cruel to people
- ☐ Has been physically cruel to animals
- ☐ Has stolen while confronting a victim
- ☐ Has forced someone into sexual activity

Destruction of Property

- ☐ Fire setting, play with matches
- ☐ Destroyed others' property

Deceitfulness or Thief

- ☐ Breaking and entering
- ☐ Often lies
- ☐ Stealing (shoplifting)

Violation of Rules

- ☐ Often stays out at night despite parental prohibition
- ☐ Has run away from home overnight
- ☐ Is often truant at school

In your opinion the severity of *Conduct Problem* is:

None 1 2 3 4 5 Severe

Other Problems:

- ☐ Memory
- ☐ Stutters
- ☐ Blanks out other people's own speech
- ☐ Poor coordination
- ☐ Rocking
- ☐ Immature
- ☐ Cries
- ☐ Difficulty getting started in AM
- ☐ Bedwetting
- ☐ Night terrors
- ☐ Sexual play
- ☐ Speech Problems
- ☐ Fumbles for the right words
- ☐ Clumsy
- ☐ Unusual physical mannerisms
- ☐ Head Banging
- ☐ Stare into space
- ☐ Spells/seizures
- ☐ Sleepwalking
- ☐ Nightmares
- ☐ Sexual problems
- ☐ Hard to control in malls (grocery shopping)