Child and Adolescent Assessment
PARENT QUESTIONNAIRE

_______________________________________ ________________ _________

Name of Child/Adolescent Date of Birth Age

PREGNANCY PROBLEMS

Please check the following for the mother of this child:

	TRUE	NOT TRUE	DON'T KNOW
1. Had bleeding during the first 3 months	_____	_____	_____
2. Had bleeding during the second 3 months	_____	_____	_____
3. Had bleeding during the last 3 months	_____	_____	_____
4. Gained less than 15 pounds, specify:	_____	_____	_____
5. Gained more than 30 pounds, specify:	_____	_____	_____
6. Had pre-eclampsia or toxemia	_____	_____	_____
7. Had to take medications; list:	_____	_____	_____
8. Took narcotic drugs; list:	_____	_____	_____
9. Drank alcohol; amount:	_____	_____	_____
10. Had previous miscarriage; number:	_____	_____	_____
11. Had premature baby(ies)	_____	_____	_____
12. Smoked 1 pack or more of cigarettes daily	_____	_____	_____
13. Labor lasted less than 2 hours	_____	_____	_____
14. Labor lasted more than 12 hours	_____	_____	_____
15. Had a difficult labor	_____	_____	_____
16. Was put to sleep for delivery	_____	_____	_____
17. Was given medication for labor; specify:	_____	_____	_____
18. Delivery was normal	_____	_____	_____
19. Delivery was breech, caesarian, forceps, induced	_____	_____	_____

20. How was the mother's health during the pregnancy of this child/adolescent? __ good __ fair __ poor __ don't know
21. How old was the mother when this child/adolescent was born? ____________
22. Was this child/adolescent born on schedule? __ 8 mths. or earlier __ term (8-10 mths) __ after 10 mths. __ don't know
23. What was this child's/adolescent's birth weight? _______ pounds ______ ounces
24. Is this child/adolescent adopted? ___ yes ___ no If yes, at what age? __________
25. Number of previous pregnancies: ___________________
26. Number of living children: ____________________

NEWBORN INFANT PROBLEMS

(First month of life)	TRUE	NOT TRUE	DON'T KNOW
1. Born with cord around neck	_____	_____	_____
2. Injured during birth	_____	_____	_____
3. Had trouble breathing	_____	_____	_____
4. Got yellow (jaundiced)	_____	_____	_____
5. Turned blue (cyanosis)	_____	_____	_____
6. Was a twin or triplet	_____	_____	_____
7. Had an infection	_____	_____	_____
8. Was given medications, specify:	_____	_____	_____
9. Had seizures	_____	_____	_____
10. Needed oxygen	_____	_____	_____
11. Was in hospital more than five days	_____	_____	_____
12. Born with a heart defect	_____	_____	_____
13. Born with other defect(s), specify:	_____	_____	_____
14. Had trouble sucking	_____	_____	_____
15. Had skin problems	_____	_____	_____
16. Colic	_____	_____	_____
17. Sleep problems	_____	_____	_____

DEVELOPMENTAL FACTORS

When did your child/adolescent do the following: (If you cannot recall the age, write either early, normal, or late.)

	Never	0-3 mo.	4-6 mo.	7-12 mo.	13-18 mo.	19-24 mo.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-7 yrs.	Since 7 yrs.
1. Hold up head											
2. Roll front to back											
3. Sit alone											
4. Crawl											
5. Walk alone											
6. Speak single words (not mama or dada)											
7. String two or more words together											
8. Toilet trained (bladder control)											
9. Toilet trained (bowel control)											
10. Attend pre-school											
11. Attend kindergarten											
12. Have difficulty separating from parents											
13. Thumb-sucking											
14. Fear of animals, darkness, etc.											
15. Nightmares											
16. Hurt self, others, animals											
17. Play with fire											
18. Run away											
19. Temper tantrums											
20. Open masturbation											
21. Afraid to go to school											
22. Behavior problems at school											
23. Academic problems at school											

24. How would you rate the activity level of the child/adolescent as an infant/toddler?
___ very active ___ active ___ average ___ less active ___ not active

25. Approximately how long did toilet training take from onset to completion?
___ less than 1 month ___ 1-2 months ___ 2-3 months ___ more than 3 months

SEXUAL MATURATION HISTORY

Did you notice any unusual behavior in your child/adolescent (i.e. cross dressing, excessive or public masturbation, sexual offenses, promiscuity, etc.)?____

At what age did your child/adolescent show adult body development?___________At what age did your child/adolescent begin menstruating? ______Was your child/adolescent prepared for these changes? ___Yes ___No Were there any special problems with the onset of menstruation? ___Yes ___No Does your child/adolescent appear comfortable with the opposite sex? ___ Yes ___ No

Is your child/adolescent sexually active? ___ Yes ___ No Have there been any pregnancies or abortions? ___ Yes ___ No

Comments:____

MEDICAL HISTORY

Please rate your child/adolescent in each of the following areas:

	GOOD	FAIR	POOR
1. Health			
2. Hearing			
3. Vision			
4. Gross motor coordination			
5. Fine motor coordination			
6. Speech articulation			

7. Has your child/adolescent had any chronic health problems (e.g. asthma, diabetes, heart condition)? ___ No ___ Yes If yes: ____
8. When was the onset of any chronic illness? ___ Birth ___ 0-1 year ___ 1-2 yrs ___ 2-3 yrs ___ 3-4 yrs. ___ over 4 yrs
9. Check which of the following illness this child/adolescent has had:
   ___ mumps ___ chicken pox ___ measles ___ whooping cough ___ scarlet fever ___ pneumonia
   ___ encephalitis ___ otitis media ___ lead poisoning ___ seizures ___other
10. Check if this child/adolescent has had any accidents resulting in the following:
   ___ broken bones ___ head injury ___ stomach pumped ___ lost teeth ___ severe lacerations ___ severe bruises
   ___ eye injury ___ stitches ___other ____
11. How many accidents has this child/adolescent had? ___ one ___ 2-3 ___ 4-7 ___ 8-12 ___ over 12
12. Check if this child/adolescent has had surgery for any of the following conditions:
   ___ tonsillitis ___ appendicitis ___ leg or arm ___ burns ___ adenoids ___digestive disorder
   ___ eye, ear, nose or throat ___ hernia ___ urinary tract ___ other __________________________________
13. How many times? ___ once ___ twice ___ 3-5 times ___ 6-8 times ___ 8 times or more
14. How long was your child/adolescent in the hospital? ___ one day ___ 2-3 days ___ 4-6 days ___ 1-4 weeks ___ 1-2 months

Please check the following problems:

	YES	NO	DON'T KNOW
15. Suspicion of alcohol or drug use	_____	_____	_____
16. History of physical/sexual abuse	_____	_____	_____
17. Sleeping problems	_____	_____	_____
18. Is this child/adolescent a restless sleeper	_____	_____	_____

19. Does this child/adolescent have bladder control problems: At night? ___ Yes ___ No If yes, how often? _______________
   During the day? ___Yes ___ No If yes, how often? ____________________
   If yes, did this child/adolescent ever have bladder control? ___ Yes ___ No If yes, explain: __________________
   ____
20. Did this child/adolescent have bowel control problems: At night? ___ Yes ___ No If yes, how often? __________________
   During the day? ___ Yes ___ No If yes, how often? _____________________
   If yes, did the child/adolescent ever have bowel control? ___ Yes ___ No If yes, explain: __________________________
   ____
21. Does this child/adolescent have any appetite control problems? ___ overeats ___ average ___ under-eats

TREATMENT HISTORY

1. Check the medications your child/adolescent has been prescribed and write in the length of time they were on medication:

MEDICATION	DURATION
Ritalin	
Tranquilizers	
Dexedrine	
Cylert	
Other	

2. Has this child/adolescent ever had any of the following forms of psychological treatment? If so, how long did it last and when was it?

   Individual psychotherapy ____

   Group psychotherapy ____

   Family therapy with child ____

   Inpatient evaluation ____

   Day hospital treatment ____

   Residential treatment ____

FAMILY HISTORY

Check if there is any history of any of the following in the family:

_____ Learning Disabilities
_____ Psychosis or Schizophrenia
_____ Anxiety Disorder
_____ Alcohol or Drug Abuse
_____ Physical or Sexual Abuse
_____ Birth Defects
_____ Nervous Breakdown
_____ Mental Retardation
_____ Depression
_____ Tics or Tourettes
_____ Arrests
_____ Hyperactivity
_____ Diabetes

LIVING SITUATION

1. Current living situation of child/adolescent: (Circle One)
   a. Both parent's home
   b. One parent's home
   c. Legal guardian's home
   d. Relative's home
   e. Friend's home
   f. Other ____
2. Primary living situation for past year: (Circle one)
   a. Both parent's home
   b. One parent's home
   c. Legal guardian's home
   d. Relative's home
   e. Friend's home
   f. Other ____

Please describe the family home: ____ House ___ Apartment ___ Condo

___ Number of rooms ___ Number of bathrooms ___ Number of bedrooms

Please indicate who sleeps in each bedroom ____

____

Please describe your neighborhood ____

____

Who has taken care of the patient most of their life? ____

Who is the primary disciplinarian in the family? ________________________________ Are they: ___ strict ___ lenient

Do parents agree on the issues of parenting, rules and discipline? ___ always ___ usually ___ sometimes ___ rarely

Do parents get along with one another? ___ always ___ usually ___ sometimes ___ rarely

Have there been or are there currently any major changes or stresses in the family where the child was raised?

___ Yes ___ No If yes, please check all the following that applies:

	In past	Current (6 months or less)
Financial problems	_____	_____
Frequent moves	_____	_____
Job changes	_____	_____
Drinking/drug problems	_____	_____
Arguments between parents	_____	_____
Separation or divorce of parents	_____	_____
Remarriage of parent(s)	_____	_____
Separation from sibling(s)	_____	_____
Separation from other family member	_____	_____
Frequent physical punishment	_____	_____
Physical confrontations between parents	_____	_____
Separation from significant non-family member	_____	_____
Mental illness in family	_____	_____
Physical illness in family	_____	_____
Psychiatric hospitalization of a parent	_____	_____
Death in the family	_____	_____
Sexual promiscuity of incestuous behavior in family	_____	_____
Family feels isolated	_____	_____
Other ____	_____	_____

How has the family been changed by the patient's problem(s)? ____

____

____

____

____

What is the family's expectations of treatment? ____

____

____

What does the family see as their role in treatment? ____

____

____

What are the family's strengths? ____

____

What are the family's weaknesses? ____

____

____

SCHOOL HISTORY

1. Please summarize the child/adolescent's progress (e.g. academic, social, testing) within each of the following grade levels:
Preschool: ____

____

Kindergarten: ____

____

Grades 1-3: ____

____

Grades 4-6: ____

____

Grades 7-12: ____

____

2. Has the child/adolescent ever been in any type of special educational program, and if so, how long?

Learning disabilities class ____

Behavioral/emotional disorders class ____

Helping teacher/content mastery ____

Speech and language therapy ____

Other ____

3. Check any of the following that apply with this child/adolescent at school:

	In what grades
Oppositional ___	________________________
Disrupt class ___	________________________
Inattentive ___	________________________
Refuse to go to school ___	________________________
Fail to turn in work ___	________________________
Disorganized ___	________________________
Detention ___	________________________
In-school suspension	________________________
Out-of-school suspension	________________________
Expelled from school	________________________

4. Have any additional instructional modifications been attempted?
___ None ___ behavior modification program ___ daily/weekly report card ___ other ______________________

5. Has this child/adolescent had any educational testing? ___ Yes ___ No
If yes, what ____ (and bring it with you to the appt.)

SOCIAL HISTORY

1. How does this child/adolescent get along with his/her brothers/sisters?
___ Doesn't have any ___ better than average ___ average ___ worse than average

2. How easily does this child/adolescent make friends? ___ Easier than average ___ average ___ worse than average

3. On the average, how long does your child/adolescent keep friendships? ___ less than 6 mths ___ 6 mths - 1 year

___ more than 1 year

4. Is your child/adolescent able to form close relationships? ___ Yes ___ No
5. Personality traits of your child/adolescent: ___ withdrawn ___ anxious ___ outgoing ___ other _________________
6. How would you describe a typical day for your child/adolescent: ____

____

CURRENT BEHAVIORAL CONCERNS

1. What are your primary concerns at this time? ____

____

____

____

2. What are other (related) concerns? ____

____

____

____

3. What strategies have been used to address these problems? (Check those that apply and circle those that have been successful):

___ Verbal reprimands ___ time out (isolation) ___ removal of privileges ___ rewards ___ physical punishment

___ giving in to the child ___ avoiding the child

4. On the average, what percentage of the time does your child/adolescent comply with initial commands?

___ 0-20% ___ 20-40% ___ 60-80% ___ 80-100%

5. On the average what percentage of the time does your child/adolescent eventually comply with commands?

___0-20% ___ 20-40% ___ 60-80% ___ 80-100%

6. To what extent are you and your spouse consistent with respect to disciplinary strategies?

___ Most of the time ___ some of the time ___ none of the time

What would you like to change about your family? ____

____

Is there anything else about the family that we should know in order to be more helpful? _________________________

____

Please mark any of the statements below which apply to your family.

	Yes	No
Our family is warm and loving	___	___
People are always fighting	___	___
Everyone goes his or her own separate way	___	___
People say what is on their minds	___	___

____ _________________________

Signature Date

Read and Reviewed by ______________________________________, Clinician, on __________________________.

To Be Completed by Clinician

Diagnostic Impression: ____

Axis I: ____

Axis II: ____

Axis III: ____

Axis IV: *Psychosocial and Environment Problems*

- *Problems with primary support group* ____
- *Problems related to the social environment* ____
- *Educational problems* ____
- *Occupational problems* ____
- *Housing problems* ____
- *Economic problems* ____
- *Problems with access to health care services* ____
- *Problems related to interaction with the legal system/crime* ___________________________
- *Other psychosocial and environmental problems* ______________________________________

Axis V: GAF Scale Past Year: _________________________ Current: ______________________

Precautions discussed with patient? ___ Yes ___ No

Preliminary Treatment Objectives: ____

____

Referral: ___ Psychiatrist ___ Psychological Testing ___ Inpatient ___ Day Hospital ___ Educational Testing

___ Other ____

Criteria for Discharge: ____

____

____

Preliminary Aftercare Plan: ____

____

____

____ ___________________________

Clinician Signature Date