

CHILD AND ADOLESCENT EVALUATION QUESTIONNAIRE

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Today's Date

Drug Allergies

Name, Address and Phone number of Pharmacy

Name of Patient

Date

Date of Birth

Sex

Home Phone Number

Address

Street

City

State

Zip

Patient's cell phone number

E-Mail

Father's Name

Age

E-Mail

Father's Occupation

Work phone #

Cell phone #

Mother's Name

Age

E-Mail

Mother's Occupation

Work phone #

Cell phone #

Stepfather's Name

Age

E-Mail

Stepfather's Occupation

Work phone #

Cell phone #

Stepmother's Name

Age

E-Mail

Stepmother's Occupation

Work phone #

Cell phone #

Child's current school

School Address

Name of Authorized School Informant

Referral Source

Phone #

Pediatrician

Phone #

Pediatrician's address

Street

City

State

Zip

Siblings, Step-Siblings, Half-Siblings (Include names, ages, school, occupation):

FAMILY CONSTELLATION

Does your child live with both natural parents? Yes No

If no please describe your child's living situation and visitation arrangements including other adults or children involved in these arrangements.

CHIEF COMPLAINT

PURPOSE OF THE EVALUATION/ CURRENT BEHAVIORAL CONCERNS:

HISTORY OF PRESENT ILLNESS - Describe when your child's symptom began and if it changed over time):

FAMILY AND SOCIAL HISTORY:

LIFE STRESSORS: (Please include any significant deaths, separations, moves, accidents, traumatic events, parent lost or changed job, changed schools, family financial problems)

What strategies have been implemented to address these problems? (Please check which have been used and note if successful)

Verbal reprimands _____ Time out _____

Removal of privileges _____ Rewards _____

Physical punishment _____ Acquiescence to child _____

Avoidance of child _____ Other _____

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

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

On the average, what percentage of the time does your child eventually comply with commands?

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

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 _____

PSYCHOLOGICAL TREATMENT Has your child had any of the following forms of psychological treatment? If so, how long did it last? (Please check all that apply)

Individual psychotherapy _____ Duration of Therapy _____

Group psychotherapy _____ Duration of Therapy _____

Family Therapy _____ Duration of Therapy _____

Inpatient Evaluation/RX _____ Duration of Inpatient Stay _____

Residential Treatment _____ Duration of placement _____

Please give additional elaboration on name of facility and cause/precipitating event of any hospitalization. _____

What Diagnosis has your child been given by child's treating professional?:

List all Medications your child is currently taking (including psychiatric, medical and over the counter):

DRUG	DOSE	START DATE	CONDITION BEING TREATED
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____

Please describe if there are/were side effects to any of the psychiatric medications (even if you are not sure if they are side effects):

What are the names and phone numbers of the physicians who are/were prescribing the medications?

Name _____ **Phone Number** _____

Which Medications? _____

Name _____ **Phone Number** _____

Which Medications? _____

Name _____ Phone Number _____

Which Medications? _____

Name _____ Phone Number _____

Which Medications? _____

Name _____ Phone Number _____

Which Medications? _____

Name _____ Phone Number _____

Which Medications? _____

PAST PSYCHIATRIC HISTORY

Describe psychiatric history and other treatments for psychiatric or behavioral symptoms with dates of treatment. Include what diagnosis you were told your child had in the past or presently has now (IMPORTANT).

ADDITONAL INFORMATION

It would be very helpful to provide any additional personal history or relevant information in this section about your child's life not found in these specific questions.

What are the names and phone numbers of the physicians who are prescribing the medications?

Name _____ **Phone Number** _____

Which Medications? _____

Name _____ **Phone Number** _____

Which Medications? _____

Please describe if there are side effects (even if you are not sure if they are side effects):

DEVELOPMENTAL HISTORY: (Prenatal, labor, delivery and peri-natal)

Age of mother at baby's birth _____ **Age of father at baby's birth** _____

Number of full term pregnancies, abortions or miscarriages and approximate dates: _____

How was the mother's health during pregnancy? _____

Do you recall using any of the following substances or medications during pregnancy?

Beer or Wine

- never
- once or twice
- 3-9 times
- 10-19 times
- 20-39 time
- 40+ times

Hard liquor

- never
- once or twice
- 3-9 times
- 10-19 times
- 20-39 times
- 40+ times

Coffee or other caffeine (coke, etc.)

Taken together, how many times?

- never
- once or twice
- 3-9 times
- 10-19 times
- 20-39 time
- 40+ times

Cigarettes

- never
- once or twice
- 3-9 times
- 10-19 times
- 20-39 times
- 40+ times

Did you take any medications during pregnancy? _____yes _____no

If yes, which medications did you take? (please include over the counter medications as well as all prescriptions) _____

Did you develop diabetes during the pregnancy? _____yes _____no

Did you develop toxemia, pre-eclampsia or eclampsia? _____yes _____no _____not sure

Was it a full term pregnancy? ___yes ___no

Was it a breach delivery? ___yes ___no

Was it a forceps delivery? ___yes ___no

Was there meconium present at delivery? ___yes ___no

Was an epidural used during delivery? _____yes _____no

Were any medications used during delivery? ____yes ____no

Was the baby delivered by c-section? ____ yes ____no

What was the baby's birth weight? _____lbs

How much weight did the mother gain? _____

How long did the baby remain in the hospital after delivery? _____days

If longer than 2 days, please state the reason. _____

Were there problems with the infant's responsiveness (alertness)? ____yes ____no ____not sure

What was the Apgar score? _____ not sure

Did your child experience any health problems during infancy? ____yes ____no ____not sure

DEVELOPMENTAL MILESTONES

Did your child have any congenital problems? [] yes [] no

If so, please describe _____

Please check one answer for each of the following questions.

1. Was your child an easy baby? (By that I mean did (s)he cry a lot? Did (s)he follow a schedule fairly well?) [] very easy [] easy [] average [] difficult [] very difficult
2. How did the baby behave with other people?
[] more social than average [] average sociability [] more sociable than average
3. When (s)he wanted something, how insistent was (s)he?
[] very insistent [] pretty insistent [] average
[] not very insistent [] not insistent at all
4. How would you rate the activity level of your child as an infant?
[] very active [] active [] average [] less active [] not active
5. At what age did (s)he smile socially? [] 2 months [] 3 months [] 4 months or more
6. At what age did (s)he sit up? [] 3-6 months [] 7-12 months [] over 12 months
7. At what age did (s)he crawl? [] 6-12 months [] 13-18 months [] over 18 months
[] not sure
8. At what age did (s)he walk? [] under one year [] 1-2 years [] 2-3 years [] not sure

9. At what age did (s)he speak single words (other than “mama” or “dada”)

- 9-13 months 14-18 months 19-24 months
 25-36 months 37-48 months not sure

10. Did your child develop stranger anxiety? yes no

11. If so, how severe? severe moderate mild

12. If so, at what age? _____ months

13. Did your child have any separations from her/his mother for over a week before the age of 2 years old? yes no

If so, for how long? _____ What were the reasons? _____

14. Has your child had any accidents resulting in the following? (Please check all that apply)

- broken bones severe lacerations head injury severe bruises
 stomach pumped eye injury lost teeth sutures
 other, please specify _____

15. How many accidents has your child had? one 2-3 4-7 8-12 more than 12

16. Has your child had any severe illnesses and at what age? _____

Was your child hospitalized yes no Please elaborate if yes. _____

17. Has your child had surgery for any of the following? (check all that apply)

- Tonsillitis Adenoids Hernia Appendicitis Eye, ear, nose or throat
 Digestive disorders Urinary tract Leg or Arm Problems
 other _____

18. Please specify number of hospitalizations and length of each stay. _____

_____.

19. Does your child have trouble sleeping?

- none difficulty falling asleep sleep continuity disturbance
 early morning awakening

20. Is your child a restless sleeper? yes no not sure

21. Does your child have bladder control problems.....at night? yes no

If yes, how often? _____

If yes, was (s)he ever continent _____

.....during the day? yes no

If yes, how often? _____

If yes, was (s)he ever continent _____

22. Does your child have bowel control problems.....at night yes no

If yes, how often? _____

If yes, was (s)he ever continent _____

.....during the day? [] yes [] no

If yes, how often? _____

If yes, was (s)he ever continent _____

23. Does your child have any appetite control problems?

[] over-eater [] average [] under-eater

(For Adolescents only)

Is there any use of drugs, alcohol or nicotine? _____ Yes _____ No _____ Not sure

If yes, please explain briefly _____

Is there any history of physical/sexual abuse? _____ Yes _____ No _____ Not sure

If yes, please explain briefly _____

MEDICAL HISTORY

Primary Physician's Name: _____ Physician's Phone No.: _____

Doctor's

Address: _____

Date of most recent physical examination. _____

Have you ever been treated for any of the following? _____

YES

NO

COMMENTS (TO BE ENTERED BY PSYCHIATRIST ONLY)

Heart Disease _____

High Blood Pressure _____

Stroke _____

Endocrine (including Diabetes) _____

Arthritis or Other Bone Problems _____

Neurological Problem/Parkinson's _____

Cataracts/other eye problems _____

Nose/Mouth/Throat _____

Hearing Problems _____

Lung/Respiratory Diseases _____

Skin Diseases _____

Urinary Problems _____

Gastro-Intestinal _____

Growths/Cancer
Hospitalizations
Major Operations
Sexually Transmitted Diseases
Kidney Disease
Liver Disease
Gynecologic Problems
Muscular Problems
Sexual Problems (inclgd., STDs)
Other Medical Problems

Have you had?

Blackouts
Convulsions or Seizures
Headaches
Tremors
Dizziness
Forgetfulness
Major Weight Loss/Gain

Do you have a history of:

Drug Abuse
Alcohol Abuse

BRIEFLY DESCRIBE ANY CURRENT MEDICAL PROBLEMS

Has anyone in your family been treated for?

	<i>YES</i>	<i>NO</i>	COMMENTS (<i>TO BE ENTERED BY PSYCHIATRIST ONLY</i>)
<u>Heart Disease</u>			
<u>High Blood Pressure</u>			
<u>Stroke</u>			
<u>Endocrine (including Diabetes)</u>			
<u>Arthritis or Other Bone Problems</u>			
<u>Neurological Problem/Parkinson's</u>			
<u>Cataracts/other eye problems</u>			
<u>Nose/Mouth/Throat</u>			
<u>Hearing Problems</u>			
<u>Lung/Respiratory Diseases</u>			
<u>Skin Diseases</u>			
<u>Urinary Problems</u>			
<u>Gastro-Intestinal</u>			
<u>Growths/Cancer</u>			

Hospitalizations
Major Operations
Sexually Transmitted Diseases
Kidney Disease
Liver Disease
Gynecologic Problems
Muscular Problems
Sexual Problems (inclgd., STDs)
Other Medical Problems

Has anyone in your family had?

Blackouts
Convulsions or Seizures
Headaches
Tremors
Dizziness
Forgetfulness
Major Weight Loss/Gain

Does anyone in your family have a history of:

Drug Abuse
Alcohol Abuse

BRIEFLY DESCRIBE ANY CURRENT MEDICAL PROBLEMS _____

FAMILY HISTORY...MOTHER

Age _____ Fertility problems (specify) _____
_____.

Education: Highest Grade Completed _____
Learning Problems (specify) _____ Grade Repeat _____
Behavior Problems (specify) _____
Medical Problems (specify) _____

Have any of your blood relatives (not including patient or his/her siblings) ever had problems similar to those your child has? _____ **If so, please describe:** _____

_____.

MOTHER OF PATIENT AND MATERNAL RELATIVES

	Self	Mother	Father	Brother	Brother	Sister	Sister
Problems with aggressiveness, defiance, & oppositional behavior as a child							
Problems with attention, over-activity, and impulse control as a child							
Learning Disabilities							
Failed to graduate from high school							
Cognitive Delays							
Psychosis or schizophrenia							
Depression for greater than two weeks							
Anxiety Disorder that impaired adjustment							
Tics or Tourette's Syndrome							
Alcohol abuse							
Substance abuse							
Anti-social behavior (assaults, thefts, etc.)							
Arrests							
Physical abuse							
Sexual abuse							

FAMILY HISTORY... FATHER

Age _____ Age at time of the patient's conception _____

Fertility problems _____

Education: Highest Grade Completed _____

Learning Problems (specify) _____ Grade Repeat _____

Behavior Problems (specify) _____

Medical Problems (specify) _____

Have any of your blood relatives (not including patient or his/her siblings) ever had problems similar to those your child has? _____ If so, please describe: _____

_____.

FATHER OF PATIENT AND PATERNAL RELATIVES

	Self	Mother	Father	Brother	Brother	Sister	Sister
Problems with aggressiveness, defiance, & oppositional behavior as a child							
Problems with attention, over-activity, and impulse control as a child							
Learning Disabilities							

Failed to graduate from high school							
Cognitive Delays							
Psychosis or schizophrenia							
Depression for greater than two weeks							
Anxiety Disorder that impaired adjustment							
Tics or Tourette's Syndrome							
Alcohol abuse							
Substance abuse							
Anti-social behavior (assaults, thefts, etc.)							
Arrests							
Physical abuse							
Sexual abuse							

SIBLINGS OF PATIENT

	Brother	Brother	Brother	Sister	Sister	Sister
Siblings' Names						
Problems with aggressiveness, defiance, & oppositional behavior as a child						
Problems with attention, over-activity, and impulse control as a child						
Learning Disabilities						
Failed to graduate from high school						
Cognitive Delays						
Psychosis or schizophrenia						
Depression for greater than two weeks						
Anxiety Disorder that impaired adjustment						
Tics or Tourette's Syndrome						
Alcohol abuse						
Substance abuse						
Anti-social behavior (assaults, thefts, etc.)						
Arrests						
Physical abuse						
Sexual abuse						

EDUCATIONAL HISTORY

Please summarize your child's progress (e.g. academic, social, testing) within each of these grade levels.

Preschool _____

Kindergarten _____

Grades 1 through 3 _____

Grades 4 through 6 _____

Grades 7 through 12 _____

Has your child ever been in any type of special education program and if so how long?

Learning Disabilities Class _____ **Duration of placement** _____

Behavioral /Emotional disorder class _____ **Duration of placement** _____

Resource Room _____ **Duration of placement** _____

Speech & Language Therapy _____ **Duration of therapy** _____

Other (specify) _____ **Duration of program** _____

Was your child ever?

1. Suspended from school? **Yes** **No** **Number of suspensions** _____

2. Retained in grade? **Yes** **No** **Number of retentions.** _____

3. Expelled from school? **Yes** **No** **Reason for expulsion** _____

Have any additional instructional modifications been attempted? (check all that apply)

None _____ Behavior Modification program _____ Daily/weekly report card _____

Other (please specify) _____

SOCIAL HISTORY

Does your child get along with his /her brothers and sisters? _____

How easily does your child make friends? _____

How many friends does your child have? _____

On the average, how long does your child keep friendships? _____

Does your child see friends after school and/or on weekends? _____

DIAGNOSTIC CRITERIA

Which of the following are considered to be significant problems at the present time?
(Check all that apply)

- Fidgets _____
- Difficulty remaining seated _____
- Easily Distracted _____
- Difficulty waiting turn _____
- Often blurts out answers to questions before
questions are completed _____
- Difficulty following instructions _____
- Difficulty sustained attention _____
- Shifts from one activity to another _____
- Difficulty playing quietly _____
- Often talks excessively _____
- Often interrupts or intrudes on others _____
- Often does not listen _____
- Often loses things _____
- Often engages in physically dangerous activities _____

When did these problems begin (specify age) _____

(Continued on following page)

Which of the following are considered to be significant problems at the present time?
(Check all that apply)

- Often loses temper _____
- Often argues with adults _____
- Often actively defies or refuse adult requests
or rules _____
- Often deliberately does things that annoy
other people _____
- Often blames others for own mistakes _____
- Is often touchy or easily annoyed by others _____
- Is often angry or resentful _____
- Is often spiteful or vindictive _____
- Often swears or uses obscene language _____

When did these problems begin? (specify age) _____

CHILDREN'S ATYPICAL DEVELOPMENT SCALE (CADS)

Below is a list of behaviors. For each item, please circle two if the item is very true or often true of your child. Circle 1 if the item is somewhat or sometimes true. If the item is not true of your child circle 0. Please answer all items as well as you can, even if some do not see to apply to your child.

0 = NOT TRUE 1 = SOMEWHAT OR SOMETIMES TRUE 2 = VERY TRUE OR OFTEN TRUE

- | | | | |
|---|---|---|---|
| 0 | 1 | 2 | 1. "Misses the point" or main idea in conversation. |
| 0 | 1 | 2 | 2. Rambling speech- one idea is not connected to the next. |
| 0 | 1 | 2 | 3. Refers to self in the third person (e.g. uses own name instead of I or me) |
| 0 | 1 | 2 | 4. Makes odd noises/talks in odd voices. |
| 0 | 1 | 2 | 5. Obsessive interest in narrow or atypical topic or even (e.g., death, the supernatural, anatomy, fantasy characters) |
| 0 | 1 | 2 | 6. Makes irrelevant comments. |
| 0 | 1 | 2 | 7. Insists on sticking to unusual routines. |
| 0 | 1 | 2 | 8. Lacks interest in toys or uses toys in unusual way. |
| 0 | 1 | 2 | 9. Strong attachments to inanimate objects. |
| 0 | 1 | 2 | 10. Unusual aversions to neutral objects or situations (e.g., will not wear certain materials, refuses to walk up a certain stairway) |
| 0 | 1 | 2 | 11. Engages in repetitive or stereotypic behavior (e.g., shakes or flaps hands, repeatedly touched hair or other material.) |
| 0 | 1 | 2 | 12. Extreme reactions to minor inconveniences or irritations. |
| 0 | 1 | 2 | 13. Difficulties dealing with change in daily schedule or routines. |
| 0 | 1 | 2 | 14. Marked lack of concern about appearance. |

- | | | | |
|--------------------------|---|---|--|
| 0 | 1 | 2 | 15. Lacks social discretion (e.g. comments on people's behavior in public without concern for their reaction or feelings.) |
| 0 | 1 | 2 | 16. Acts as if other people were not in the same room. |
| 0 | 1 | 2 | 17. Poor judge of other people's reactions or feelings. |
| 0 | 1 | 2 | 18. Reveals overly personal detail to acquaintances or strangers. |
| 0 | 1 | 2 | 19. Lacks interest in peers. |
| 0 | 1 | 2 | 20. Makes poor eye contact with others. |
| 0 | 1 | 2 | 21. Does not appreciate personal space (e.g., stands too close or talks with Back to person) |
| 0 | 1 | 2 | 22. Mood changes quickly without apparent reason. |
| 0 | 1 | 2 | 23. Describes the details of an event but misses the meaning or importance of it. |
| 0 | 1 | 2 | 24. Sits, stands or walks in odd postures. |
| 0 | 1 | 2 | 25. Attributes meaning to events that are simply a coincidence. |
| 0 | 1 | 2 | 26. Believes others are talking about him/her when others are speaking softly among themselves. |
| 0 | 1 | 2 | 27. Overly suspicious of others. |
| 0 | 1 | 2 | 28. Confuses the sequence in which events occurred when describing them. |
| 0 | 1 | 2 | 29. Lacks compassion when others are hurt or finds it humorous. |
| 0 | 1 | 2 | 30. Laughs or cries for little apparent reason. |
| 0 | 1 | 2 | 31. Attends to background or distant sound that others would ignore. |
| (continued on next page) | | | |
| 0 | 1 | 2 | 32. Excessively preoccupied with violent stores, TV shows or weapons. |
| 0 | 1 | 2 | 33. Confuses the causes of events or fails to understand how events cause other events. |
| 0 | 1 | 2 | 34. Draws excessively detailed pictures. |
| 0 | 1 | 2 | 35. Dislikes being held or touched. |
| 0 | 1 | 2 | 36. Keeps a diary or journal of rambling thoughts or random ideas. |
| 0 | 1 | 2 | 37. Speaks in half-thought or incomplete phrases without concern for whether others can understand or follow his/her ideas. |
| 0 | 1 | 2 | 38. Gets angry for little apparent reason. |
| 0 | 1 | 2 | 39. Has unusual fears not typical for his/her age group (e.g., afraid to take shower or put head under the water after 6 years of age. |
| 0 | 1 | 2 | 40. Hoards worthless objects that have no apparent meaning or value. |
| 0 | 1 | 2 | 41. Speaks in excessively loud or soft voice. |
| 0 | 1 | 2 | 42. Overreacts to pain (e.g., bumps leg and screams and cries excessively) |
| 0 | 1 | 2 | 43. Exhibits ritualistic behaviors (e.g. has to line up toys in a particular order after using the. |
| 0 | 1 | 2 | 44. Spends an unusual amount of time fantasizing. |
| 0 | 1 | 2 | 45. Mouths or chews objects. |
| 0 | 1 | 2 | 46. Seems to be extremely naïve for his/her age (e.g., believes anything he/she is told. |
| 0 | 1 | 2 | 47. Does not respond to the initiations of other children. |
| 0 | 1 | 2 | 48. Picks nose, skin, or other parts of the body. |
| 0 | 1 | 2 | 49. Makes bizarre statements. |
| 0 | 1 | 2 | 50. Interacts with acquaintances and strangers in a similar manner. |
| 0 | 1 | 2 | 51. Hits or bites self. |
| 0 | 1 | 2 | 52. Repeats certain acts over and over. |
| 0 | 1 | 2 | 53. Lacks modesty for his/her age. |

YOU MUST COMPLETE THIS SECTION

TEMPERMENTAL TRAITS

(PLEASE CIRCLE ALL THOSE THAT APPLY)

- | | | |
|--|--|--|
| 1. Bodily complains:
hypochondriasis | 18. Opinionated;
dogmatic | 35. Hypercritical of
others. |
| 2. Dissatisfaction
(chronic) or lack of
pleasure | 19. Alcoholism | 36. Quarrelsome. |
| 3. Easy fatigability | 20. Arrogance | 37. Resentful |
| 4. Guilt over minor
indiscretions. | 21. Boastfulness | 38. Suspicious (marked)
or <u>intense</u> jealousy. |
| 5. Indecisiveness. | 22. Distractibility. | 39. Eccentric |
| 6. Inordinate
examination fear. | 23. Extraverted; very
“out-going” | 40. Excessively
reserved. |
| 7. Joylessness. | 24. Heightened self
confidence; over-
optimism, mild
euphoria | 41. “Loner” |
| 8. Lack of initiative | 25. Hyper-sexuality or
promiscuity(for
adolescents) | 42. Self-consciousness
(severe) |
| 9. Pessimism | 26. Insensitivity or
coarseness | 43. Shyness (moderate
to extreme) |
| 10. Self doubt: excessive
worrying | 27. Lack of insight | 44. Superstitious |
| 11. Terrifying dreams | 28. Over-spending. | 45. Unsociable. |
| 12. Abusiveness | 29. Stubbornness | 46. Withdrawn |
| 13. Heightened
premenstrual
irritability. | 30. Taking too much,
or too loud. | 47. Overly sensitive. |
| 14. Impulsivity | 31. Teasing others
inordinately | |
| 15. Irritability | 32. Blames others. | |
| 16. Jealousy | 33. Grudge-holding;
unforgiving. | |
| 17. Mildly irascible | 34. Humorless. | |