CHILD PSYCHIATRIC QUESTIONNAIRE

Developed by
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Dear Patients/ Parents/ Caretakers: Please carefully fill in this form prior to your first appointment in order to help us reduce the time and cost of gathering this information at our office. We appreciate your cooperation and patience.

Patient's Name: _____

Date of Birth: ____/____/____ ***Patient's Birthplace***:_____ ***Sex***: ❑ M ❑ F

Race: ❑ African-American ❑ Caucasian ❑ Latino ❑ Asian ❑ Other _____

Person completing this form:_____ ***Relation to child***:_____

• Who referred you for an evaluation? _____

• Please briefly describe the problems for which you are seeking help at this time.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

• Approximately when did the problem(s) begin? _____

_____

_____

• Any known stress cause or contribute to the problem(s)? ❑**No** ❑**Yes**

*If Yes, please describe stress:*_____

_____

● Has the patient ever received outpatient mental health treatment? ❑ **No** ❑ **Yes**

If yes, please list in order, including Psychological or IQ/School testing:

Clinician/ Doctor	Date(s) of Evaluation or Treatment	Type of Evaluation or Treatment	Frequency of visits

● Has the patient ever received inpatient mental health treatment? ❑ **No** ❑ **Yes**

If yes, please list in order:

Hospital Name	Dates of Treatment	Reason for hospitalization

● If your child has ever taken psychiatric medications, please list them below: ❑ **Not applicable**

Rx Name	Reason Given	Highest Dose	% Improvement	Side-effects	Dates Taken

● Has your child ever threatened or attempted suicide? ❑ **No** ❑ **Yes** If yes, please describe:

_____

_____

● Has your child ever had any brain imaging or functional studies? *(MRI, CAT scan, EEG, etc.)*

❑ **No** ❑ **Yes**

Family Psychiatric History: *(Please note ADHD, Learning Disorders, Depression, Bipolar Disorder, Anxiety Disorders, Obsessive-Compulsive Disorder, Tic/ Tourette's, Schizophrenia, Drug or Alcohol Abuse, Suicide attempts, or other Psychiatric Problems).*

- Is there a history of ADHD, mental illness, mental retardation, learning problems, alcohol or drug abuse in the patient's grandparents, parents, siblings, or 1st cousins?……❑ **No** ❑ **Yes**

If Yes, please fill in the following chart:

Affected Family Member	Type of Mental Illness or SA	Treatment (if any)

Childhood Development:

- ***Pregnancy---***Please check any that apply to the mother's pregnancy with this child:

Describe

- ❑ Received prenatal care _____
- ❑ Drank alcohol during pregnancy _____
- ❑ Smoked during pregnancy _____
- ❑ Used drugs during pregnancy _____
- ❑ Took medications _____
- ❑ Infection(s) _____
- ❑ Nausea or Vomiting _____
- ❑ Severe Emotional Distress _____
- ❑ Elevated blood pressure _____
- ❑ Diabetes of pregnancy _____
- ❑ Pre-eclampsia _____
- ❑ Premature labor _____
- ❑ Threatened miscarriage _____

- ***Birth History:***

Mother's age at time of birth: _____ years old. Father's age at time of birth: _____ years old.

Was mother given medication or anesthesia?……❑ **Don't know** ❑ **No** ❑ **Yes**

Delivery was: ……❑ **Spontaneous Vaginal** ❑ **Induced** ❑ **Caesarian section**

Any complications with labor or delivery?…… … ❑ **No** ❑ **Yes** _____

Was the baby premature? …… ❑ **No** ❑ **Yes** _____

Baby's birthweight: _____lbs _____oz

Did baby have any of the following:

Breathing problems…….	❑ **No**	❑ **Yes**
Cord around the neck……...	❑ **No**	❑ **Yes**
Abnormal color ……	❑ **No**	❑ **Yes**
Abnormal tone ……..……	❑ **No**	❑ **Yes**
Meconium ……..……..	❑ **No**	❑ **Yes**
Failure to thrive ……	❑ **No**	❑ **Yes**
Jaundice ……	❑ **No**	❑ **Yes**
Infection …….	❑ **No**	❑ **Yes**

- ***Developmental Milestones*** *(answer as best you can recall)*

  Motor Development (sitting, crawling, walking)……. ❑ **Normal** ❑ **Fast** ❑ **Slow**

  Speech & Language ……. ❑ **Normal** ❑ **Fast** ❑ **Slow**

  Self-help skills (dressing, brushing, toileting, hygiene) ……. ❑ **Normal** ❑ **Fast** ❑ **Slow**

- ***Temperament as Infant:*** ❑ **Easy baby** ❑ **Slow to Warm up** ❑ **Difficult/ "Colicky"**

Medical History:

- Who is your child's Pediatrician or Family Doctor? _____
- When was your child's last physical examination? _____
- Current Medications *(include Over-the-counter meds, Vitamins, Herbs, or Supplements)*

  ❑ **None** OR Please List:

Rx Name	Dosage	Frequency	Prescribing M.D.

- Does your child have any drug allergies? ❑ **No** ❑ **Yes** *(please list):*

  _____

- Does your child have any current medical problems? ❑ **No** ❑ **Yes** *(please list):*

  _____

- Please check & briefly describe if your child has experienced any of the following conditions:

  ❑ Surgeries _____
  ❑ Chest pain _____
  ❑ Abnormal heart rate or rhythm _____
  ❑ High Blood Pressure _____
  ❑ Seizures/Convulsions _____
  ❑ Staring spells _____
  ❑ Head injury _____
  ❑ Frequent Strep Throat infections _____
  ❑ Frequent Headaches _____
  ❑ Frequent Stomach Aches _____
  ❑ Vision problems _____
  ❑ Hearing problems _____
  ❑ Significant accidents or injuries _____
  ❑ Bedwetting _____
  ❑ Fecal soiling of clothes _____
  ❑ Exposure to Lead or Mercury_____

Social History:

- City of Residence: _____
- Now Living with: ❑ **Both Bio parents** ❑ **Bio Father** ❑ **Bio Mother** ❑**Other:**_____
- Other Children in family:
  Names & Ages: _____ _____
  _____ _____
- Is the child adopted?…….…… ❑ **No** ❑ **Yes**
  *If Yes, Please describe the circumstances of the adoption:*_____
  _____
- Has the patient ever experienced or witnessed any physical abuse, sexual abuse, or neglect?
  ❑ **No** ❑ **Yes**
  If Yes, please briefly describe: _____
  _____
- Hobbies/ Interests: _____
- Any concerns about peer relationships/ social skills? _____

School History:

- Name of School: _____ Grade: _____

Current Academic Performance: …….	❑ **Good**	❑ **Fair**	❑ **Poor**
Past Academic Performance: ……...	❑ **Good**	❑ **Fair**	❑ **Poor**
Current Behavioral Performance: ……	❑ **Good**	❑ **Fair**	❑ **Poor**
Past Behavioral Performance: …….	❑ **Good**	❑ **Fair**	❑ **Poor**

- Grades Repeated: _____
- Is child in any special education programs? ……. ……... ❑ **No** ❑ **Yes** (*explain*):
  _____
- Any known Learning Disabilities? …… ……. ❑ **No** ❑ **Yes** (*explain*):
  _____

Legal Problems:

- Has your child has ever been arrested or had legal charges?…….. ❑ **No** ❑ **Yes** (explain):
  _____

Substance Use:

- Do you suspect that your child has ever used tobacco, alcohol, or drugs? ❑ **No** ❑ **Yes** (explain):
  _____
  _____

Religious Beliefs:

❑ None ❑ Jewish ❑ Muslim ❑ Hindu ❑ Christian (*denomination*) _____ ❑ Other