CHILD PSYCHIATRIC QUESTIONNAIRE

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: _____ ***Relations 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)? ☐ Yes ☐ No**
  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? ☐Yes☐ No**

If yes, please list in order:

Hospital Name	Date 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 Members	Type of 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 the time of birth: _____ years old. Father's age at time of birth; _____ years old.

Was the mother given medication or anesthesia?.....☐Don't know ☐No ☐Yes

Delivery was:……..☐Spontaneous Vaginal ☐Induced ☐Caesarian section

Any complication with labor or delivery?.....☐No ☐Yes _____

Was the baby premature?.....☐No ☐Yes _____

Baby's weight: _____ lbs _____ oz

Did baby have any of the following: *Breathing problems…….*☐Yes ☐No
Cord around the neck……..☐Yes ☐No
Abnormal color……
Meconium……..
Failure to thrive……
Jaundice……..
Infection…...

- ***Development Milestones*** (*answer as best as you can recall)*
  Motor Development (sitting, crawling, walking).....

  Speech & Language……

  Self-help skills (dressing, brushing, toileting, hygiene)....

- ***Temperament as Infant:*** ☐**Easy baby** ☐**Slow to Warm up** ☐**Difficult**

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 relationship/social skills?*

_____

_____

School History:

- Name of School: _____ Grade: _____

Current Academic Performance:.....
Past Academic Performance:.....
Current Behavioral Performance:.....
Past Behavioral Performance:.....

- Grade Represented: _____

- Is child in any special education programs?.....
  ☐No ☐Yes *(explain):*

_____

- Any known Learning Disabilities?.....
  ☐No ☐Yes *(explain):*

_____

_____

Legal Problems:

- Has your child 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