

Alabama Psychiatric Services, P.C.
Initial Assessment Child/Adolescent Program
Parent Questionnaire
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Clinician Notes:

Date: _____

Patient Name: _____ Date of Birth: ____/____/____

Age of Patient: _____ Name of person completing this form _____

Relationship to Patient: _____

Dear Parent: The information that you provide is critical in providing an accurate diagnosis and treatment of the problem. If you require additional space to answer any of these questions, please write on the back of the page and list the number of the question being answered. If you do not know the answer to a question please leave it blank.

I. Please describe, in detail, the present problem (including when the problem started, how often it occurs, what stressors may contribute to the problem, etc.)

Has your child received any previous treatment for the problem? Yes No If yes, explain:

II. Medical History:

Name of Pediatrician or Family Doctor: _____

Date last seen: _____

Would you like our findings and recommendations sent to your pediatrician? Yes No

Please check any of the following medical conditions for which your child was ever evaluated or diagnosed:

- | | | | |
|---|---|--|--------------------------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Weight Problems | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Asthmatic condition | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Chronic Hearing Loss | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Other _____ | | | |

Please explain any item that you checked and list any medication(s) that were *previously* prescribed.

Allergies (Please list all of your child's allergies):

Current Medications (Please list all of your child's current medications other than above):

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Signature:

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Clinician Notes:

III. Past Psychiatric/Psychological History:

Has your child ever received psychiatric services or counseling? Yes No If yes, please explain and include dates of service, location, physician or counselor's name.

List any psychiatric or mood medications that your child has been prescribed in the past (if more than 3 medications, use the back of this page):

<u>Name of medication</u>	<u>Prescribed by</u>	<u>Dose level</u>	<u>Side effects</u>
1.			
2.			
3.			

IV: Developmental History:

A: Relating to your child's birth:

Your child's weight at birth: ___ lbs. ___ oz. Was this a full term birth? Yes No If no, explain:

Did either parent use drugs or alcohol at the time of conception? Yes No If yes, explain:

Were there any complications with the labor & delivery such as jaundice, infection etc.? Yes No If yes, explain:

Were there any problems after birth? Yes No If yes, explain:

B. Pre-school/Toddler Temperament: Please check the following items that apply.

- | | | |
|---|---|---|
| <input type="checkbox"/> Did not enjoy being held | <input type="checkbox"/> Excessive restlessness | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Feeding problems | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Head-banging |
| <input type="checkbox"/> Sensitive to light / noise / texture | <input type="checkbox"/> Fussy or unhappy | <input type="checkbox"/> Difficulty bonding |

C. Developmental Milestones: Please indicate the approximate age in months when your child achieved the following tasks:

_____ Sitting alone _____ Walking _____ Put words together _____ Toilet trained

D. Unusual behaviors/Speech patterns:

- | | | |
|--|--|---|
| <input type="checkbox"/> Spinning | <input type="checkbox"/> Putting things in the mouth | <input type="checkbox"/> Repeating words or phrases inappropriately |
| <input type="checkbox"/> Hand flapping | <input type="checkbox"/> Sniffing excessively | <input type="checkbox"/> Saying "I" for "You" |

V. School/daycare History:

Did your child attend daycare? Yes No If yes, what was their age? _____ Any problems? _____

What were your child's grades on their last report card? _____

What is the name of your child's primary teacher? _____

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Clinician Notes:

Name of Current School:	Dates Attended	Present Grade Placement	Behavior Problems	Learning Problems
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Past Schools:	Dates Attended	Present Grade Placement	Behavior Problems	Learning Problems
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Has your child ever been:
 evaluated for a learning disability? Yes No If yes, what grade? _____ When? _____

placed in Special Education Classes? Yes No If yes, what type of class? _____

tested by the school system? Yes No If yes, when? _____

expelled or suspended? Yes No If yes, please describe: _____

Does your child have a current IEP (Individual Education Plan)? Yes No

Does your child have a current 504 plan? Yes No

VI. Legal / Juvenile Court / Alabama State Department of Human Resources (DHR):

Has your child been: arrested? Yes No
 assigned a probation officer? Yes No If yes, their name: _____
 jailed? Yes No

Has your child: ever appeared in juvenile court? Yes No
 or other family member ever been reported to DHR? Yes No
 been assigned a DHR caseworker? Yes No
 If yes, their name: _____
 ever been a victim of child physical or sexual abuse? Yes No

If you answered yes to any of these questions, please explain:

VII. Family Medical History:

<input type="checkbox"/> Sudden death	<input type="checkbox"/> Heart disease (especially dysrhythmias)	<input type="checkbox"/> Diabetes mellitus
<input type="checkbox"/> Obesity	<input type="checkbox"/> Narrow Angle Glaucoma	<input type="checkbox"/> Seizures

Clinician
 Signature: _____

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Clinician Notes:

VIII. Family Psychiatric History:

Has any member of your child's family been treated for depression, bipolar disorder, schizophrenia, anxiety, suicidal thoughts, alcohol or other drug problems, learning disabilities or ADD/ADHD, etc.? Yes No If yes, please explain:

IX. Social / Family History:

Biological mothers' full name: _____ Biological fathers' full name: _____

Biological parents marital status: Married to each other Divorced Separated

If divorced from one another, has either remarried? Mother Yes No
Father Yes No

If the biological parents are divorced or separated, who has custody of the patient? _____

Type of custody? _____

Stepmothers' name: _____

Stepfathers' name: _____

List all relatives who presently live in the same household as your child (if more than 5 please list on back of this sheet):

<u>Name</u>	<u>Relationship</u>	<u>Type of Employment / Student Grade Level</u>
1.		
2.		
3.		
4.		
5.		

Please check any of the following stressors that presently affect your child:

- | | | |
|--|---|--|
| <input type="checkbox"/> Family financial problems | <input type="checkbox"/> Family relationships | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> Child rearing problems | <input type="checkbox"/> Drug or alcohol problems | <input type="checkbox"/> Abuse behavior |
| <input type="checkbox"/> Health problems | <input type="checkbox"/> Employment problems | <input type="checkbox"/> School problems |
| <input type="checkbox"/> Peer relationships | <input type="checkbox"/> Frequent change of household | <input type="checkbox"/> Frequent moves |
| <input type="checkbox"/> "Other" problem _____ | | |

Please explain how any item you checked affects your child.

Clinician
Signature:

Reminder: Please bring a copy of any custody papers to the initial appointment.