4898 Valleydale Road Suite B-4
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Initial Assessment Child/Adolescent Program Parent Questionnaire Page 1

Patient Name: _____ Date: _____

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.

II. Medical History:
Name of Pediatrician or Family Doctor: _____ Date last seen: _____

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

Seizures	Asthmatic condition	Chronic Hearing Loss	Stomach Problems
Weight Problems	Chronic Headaches	Suicidal Thoughts	Head Injury
Depression	Heart Problems	Chronic Fatigue	

Surgeries:_____ Other _____

Please explain any item that you circle 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)**:**

_____
_____

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:

_____
_____
_____
_____

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? _____

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):

_____
_____
_____

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.

Did not enjoy being held	Feeding problems	Sensitive to light / noise / texture
Excessive restlessness	Sleep problems	Fussy or unhappy
Colic	Head-banging	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:

Spinning	Putting things in the mouth	Repeating words or phrases inappropriately
Hand flapping	Sniffing excessively	Saying "I" for "You"

Name of **Current School**: _____ Current Grade: _____

Please describe any academic or behavioral difficulties:
_____
_____

Name of **Past Schools**:
_____ Grades Attended _____

_____ Grades Attended_____

Has your child ever been: evaluated for a learning disability?	Yes	No
Placed in Special Education Classes?	Yes	No
Does your child have a current IEP (Individual Education Plan)?	Yes	No
Does your child have a current 504 plan?	Yes	No

VII. Family Medical History:

Sudden death	Heart disease (especially dysrhythmias)	Obesity
Narrow Angle Glaucoma	Diabetes mellitus	Seizures

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

Has your child been: arrested? Yes No

Assigned a probation officer? Yes No

Jailed? Yes No

Has your child ever appeared in juvenile court? Yes No

Has any family member ever been reported to DHR? Yes No

Has your child or family been assigned a DHR caseworker? Yes No

If yes, their name: _____

Has your child ever been a victim of child physical or sexual abuse? Yes No
If you answered yes to any of these questions, please explain:

_____
_____
_____
_____
_____

IX. Social / Family History:

FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

_____

Parents' current marital status:

[ ] married to each other
[ ] separated for ___ years
[ ] divorced for ___ years
[ ] mother remarried ___ times
[ ] father remarried ___ times
[ ] mother involved with someone
[ ] father involved with someone
[ ] mother deceased for ___ years
age of patient at mother's death ___
[ ] father deceased for ___ years
age of patient at father's death ___

Describe childhood family experience:

[ ] outstanding home environment
[ ] normal home environment
[ ] chaotic home environment

Describe parents:	**Father**	**Mother**
full name	_____	_____
occupation	_____	_____
education	_____	_____
general health	_____	_____

physical/verbal/sexual abuse toward others [ ] witnessed [ ] experienced

physical/verbal/sexual abuse from others [ ] witnessed [ ] experienced

Special circumstances in childhood: _____

_____

_____

IMMEDIATE FAMILY

List all persons currently living in patient's household:

Name	Age	Sex	Relationship to patient
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List children <u>not</u> living in same household as patient:

Name	Age	Sex	Relationship to patient
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe any past or current significant issues in other <u>immediate family</u> relationships: _____

_____

_____