Akron Children's Hospital

Child's Name: _____ D.O.B. _____

Pediatric Psychiatry/Psychology Family Questionnaire

Thank you very much for completing this form. This will help prepare you for the kind of information that will be further explored during the evaluation process. If you have documents related to this information, please bring copies with you to the evaluation to share with the staff member.

Presenting Concern:

Briefly describe your reason(s) for seeking our services for your child/adolescent?

Please list the name of all **Current Prescription Medications** your child is taking.	Dose	At what time of day?	How long has your child been taking this?	Who prescribes this medication?
Please bring the bottles of all currently prescribed medications to the first evaluation session				

Current Treatment for Behavioral or Emotional Problems:

Current Therapist/Counselor:		
Current Psychiatrist:		
Current Case Worker:		Agency:
Current Psychiatric Diagnosis (if known):		

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Past Treatment for Behavioral or Emotional Problems:	
Past Therapist/Counselor:	
Past Psychiatrist:	
Past Psychiatric Diagnosis (if known):	
Past Medications used to treat behavioral and/or emotional problems (and doses):	
Has your child ever been psychiatrically hospitalized? ❑ Yes ❑ No **If Yes, please bring enough information about this to the first session to sign a Release of Information**	
Has your child ever threatened to kill him/herself? ❑ Yes ❑ No	
Has your child ever attempted to kill him/herself? ❑ Yes ❑ No	
Has your child ever attempted to seriously harm (or mutilate) him/herself? ❑ Yes ❑ No	
Has your child ever threatened to seriously harm someone else? ❑ Yes ❑ No	
Has your child ever attempted to seriously harm someone else? ❑ Yes ❑ No	
Has your child ever seriously harmed someone else? ❑ Yes ❑ No	

Substance Use History:		
Has your child ever used alcohol, illicit drugs or prescription medications that were not her/his?	❑ Yes ❑ No	If No, then go on to the next section
Has your child's use of these drugs/medications ever caused problems in her/his life?	❑ Yes ❑ No	If Yes, please explain:

Pregnancy/Birth/Developmental History:			
Did the child's mother use any of the items listed below while she was pregnant with the child?			
Alcohol	❑ Yes ❑ No ❑ Don't Know	Caffeine	❑ Yes ❑ No ❑ Don't Know
Cigarettes	❑ Yes ❑ No ❑ Don't Know	Illicit Drugs	❑ Yes ❑ No ❑ Don't Know
Did the mother/child have any unusual complications during the pregnancy and/or during the birth of the child? ❑ Yes ❑ No			
Was your child born: ❑ Full Term ❑ Premature			

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Please check the box that best describes your child	Slow	Average	Fast	Don't know	Please check the box that best describes your child	Slow	Average	Fast	Don't know
Played with others	❑	❑	❑	❑	Crawled	❑	❑	❑	❑
Learned new things	❑	❑	❑	❑	Walked	❑	❑	❑	❑
Used age-appropriate speech	❑	❑	❑	❑	Showed feelings	❑	❑	❑	❑
Care of personal hygiene	❑	❑	❑	❑	Physical growth	❑	❑	❑	❑
Toilet trained	❑	❑	❑	❑					

Social History:

Please list everyone living in the same household with the child:

Name	Relationship to Child	Age

	Mother	**Father**
Name:		
Current Address:		
Relationship (check one):	❑ Biological ❑ Step ❑ Adoptive ❑ Foster	❑ Biological ❑ Step ❑ Adoptive ❑ Foster
Birth Date:		
Marital Status (check one):	❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed	❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed
Education (circle highest grade completed):	1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 ___ Graduate/Professional: 1 2 3 4 beyond ❑ Vocational ❑ Technical ❑ Business Degree	1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 ___ Graduate/Professional: 1 2 3 4 beyond ❑ Vocational ❑ Technical ❑ Business Degree
Ethnic Group (check one):	❑ African American ❑ Asian American ❑ Caucasian ❑ Hispanic ❑ Multiethnic ❑ Other	❑ African American ❑ Asian American ❑ Caucasian ❑ Hispanic ❑ Multiethnic ❑ Other
Religion:		

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	Mother	Father
Contact Phone Numbers	Home: Cell: Work:	Home: Cell: Work:

Is Your Family Voluntarily Seeking Treatment? ❑ Yes ❑ No

Who Has Financial Responsibility?

Insurance (Primary & Secondary):

Who Has Legal Custody? ❑ Mother ❑ Father ❑ Both ❑ Relative ❑ Outside Agency ❑ Other

If other than parent, please list legal guardian:

If your child has been known by any other name, please list:

If court ordered custody, what type? ❑ Permanent ❑ Temporary ❑ Protective ❑ Emergency

Is your child currently the subject of a custody dispute?	❑ Yes ❑ No	If Yes, please explain below:
Is there any court order that specifically prohibits either the mother or the father of the child from accessing information in medical records?	❑ Yes ❑ No	If Yes, please explain below:

If there are any court documents involving the custody of your child, please bring a copy of them to the first evaluation session

Are there weapons in the home?	❑ Yes ❑ No	If Yes, are the weapons locked up or secured?	❑ Yes ❑ No

Has your child/adolescent ever…

…experienced or viewed a physically traumatic or life threatening event?	❑ Yes ❑ No	If yes, what age?	
…been neglected (not fed, clothed, etc)?	❑ Yes ❑ No	If yes, at what age?	Reported? ❑ Yes ❑ No
…been sexually abused, exploited, or raped?	❑ Yes ❑ No	If yes, at what age?	Reported? ❑ Yes ❑ No
…been physically abused, or assaulted?	❑ Yes ❑ No	If yes, at what age?	Reported? ❑ Yes ❑ No

Current Services Involvement: (check all that apply)

❑ Protective Service (County) _____ ❑ Domestic Relations ❑ "Cluster"
❑ Alcohol & Drug Addiction Service Board ❑ Bd. Of Vocational Rehabilitation ❑ Juvenile Court
❑ Other legal involvement ❑ MR/DD Board ❑ Other community agency

Has your child, or another family member in the household, ever been involved, in any way, with Protective Services or other similar agencies?	❑ Yes ❑ No	If Yes, please explain:

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Has your child/adolescent ever been placed out of your care?	❑ Yes ❑ No	If Yes, at what age?
Are there any other medical/financial/personal or other stresses in your family at this time? *(Such as a death in the family, divorce or separation, job loss, change in who lives with the child, school change, major illness, family move, etc)*		

Interests/ Hobbies:

Please list your child's/adolescent's: interests, hobbies, leisure, community/school activities, & support systems:
What strengths does your child have?

Beliefs:

Do you or your child/adolescent have a religious, cultural, or spiritual belief that we should be aware of during this evaluation and when planning your child's care? ❑ Yes ❑ No	If Yes, please describe:
Are there issues regarding the way your child/adolescent perceives her/his sexual/gender identity that we should be aware of? ❑ Yes ❑ No	If Yes, please describe:

School Situation & History:

What school is your child currently attending? School District?
Current Grade Average:
If your child in regular classes without a Special Education IEP? ❑ Yes ❑ No ❑ Don't know
Has your child had a recent MFE (Multi-Factorial Evaluation)? ❑ Yes ❑ No ❑ Don't know **If Yes, please bring a copy of the MFE to the first evaluation session**
Has the school developed special services/programming for your child? (Check which apply) ❑ IFSP (Under age of 5) ❑ IEP (Over age of 5) ❑ 504 Accommodation Plan **If your child has an IEP or 504 Plan, please bring a copy of it to the first evaluation session**

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Eligible Condition for IEP: ❑ Severe behavior handicap (SBH) ❑ Emotionally Disturbed (ED) ❑ Multi-handicapped (MH) ❑ Hearing Handicapped (HH) ❑ Developmentally Handicapped (DH) ❑ Visually Handicapped (VH) ❑ Specific Learning Disabled (SLD) ❑ Other:
Current problems in school? ❑ Yes ❑ No

Did your child attend an infant therapy program? ❑ Yes ❑ No	
Did your child attend preschool? ❑ Yes ❑ No	
Has the school psychologist ever tested your child? ❑ Yes ❑ No ❑ Don't know	
Has your child/adolescent ever repeated a grade? ❑ Yes ❑ No	If yes, which grade(s)?
How your child/adolescent ever been suspended or expelled? ❑ Yes ❑ No	If Yes, when?
Approximately how many days of school did your child miss last year for any reason?	

Employment History:

Is your child currently employed? ❑ Yes ❑ No If Yes, where?
Has your child ever been employed in the past? ❑ Yes ❑ No If Yes, where?
Has your child received vocational training? ? ❑ Yes ❑ No If Yes, where?

Legal History:

Has your child ever been involved with the police or Juvenile Court?	❑ Yes ❑ No If Yes, please explain:
If Yes, please bring a copy of the court documents to the first evaluation session	

Family Psychiatric History:

Has anyone in your family that is biologically related to your child had a history of:

ADHD	❑ Yes ❑ No	If yes, who?
Anxiety Disorder/Panic Attacks	❑ Yes ❑ No	If yes, who?
Bipolar Disorder (Manic Depression)	❑ Yes ❑ No	If yes, who?
Depression	❑ Yes ❑ No	If yes, who?
Eating Disorders	❑ Yes ❑ No	If yes, who?
Schizophrenia	❑ Yes ❑ No	If yes, who?
Substance/Alcohol Abuse	❑ Yes ❑ No	If yes, who?
Suicide/Suicidal Ideation	❑ Yes ❑ No	If yes, who?
Other psychiatric problem:	❑ Yes ❑ No	If yes, who?

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Treatment Expectations:	
In what areas do you want your child to improve as a result of the evaluation and treatment?	
How will you determine whether your child has improved during or after treatment?	
Name of person completing Family Questionnaire:	Relationship to client:

Office Use Only:
I have reviewed this Family Questionnaire

Signature _____ Date _____ Time _____

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Physical Health Screening

Child/Adolescent's **Primary Care Physician** (PCP):		
Address:		
City:	State:	Zip:
Phone Number:		
Please bring enough information about your PCP to the first session to sign a Release of Information		
Date of your child/adolescent's last check-up:		
Were you told of any problems at this check-up?		❑ Yes ❑ No
If Yes, please explain:		
Does your child/adolescent have any physical/developmental disabilities?		❑ Yes ❑ No
If Yes, please explain:		
Does your child/adolescent have any vision/motor/communication/hearing problems?		❑ Yes ❑ No
If Yes, please explain:		
Does your child/adolescent have chronic medical problems? (Asthma, Diabetes, etc.)		❑ Yes ❑ No
If Yes, please explain:		
Does your child/adolescent have any restrictions due to illness/injury?		❑ Yes ❑ No
If Yes, please explain:		

Nutritional Screening

Your child/adolescent's height:	Your child's weight:	❑ *No problem with nutrition*
Please check all that apply		
Eating: ❑ More ❑ Less ❑ Not eating	*Drinking:* ❑ More ❑ Less ❑ Takes liquids only	
Appetite: ❑ Increased ❑ Decreased	❑ *Nausea*	❑ *Trouble Chewing or Swallowing*
Does your child/adolescent have a special diet?	❑ Yes ❑ No	If Yes, what type of diet?
If your child/adolescent has a special diet, do they comply with the special diet?		❑ Yes ❑ No
If No, please explain:		
Does your child/adolescent have any dental problems?		❑ Yes ❑ No
If Yes, please explain:		

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Nutritional Screening – Continued *Please answer the following questions*	
Does your child/adolescent have any known food allergies?	❑ Yes ❑ No
If Yes, please explain:	
Has your child/adolescent experienced any changes in their bowel habits in the past year?	❑ Yes ❑ No
If Yes, please explain:	
Does your child/adolescent have eating habits/behaviors that may be indicators of an eating disorder? (bingeing, inducing vomiting)	❑ Yes ❑ No
If Yes, please explain:	
Has your child/adolescent lost or gained ten (10) pounds or more in the last three (3) months?	❑ Yes ❑ No
If Yes, please explain:	
Other concerns about your child/adolescent's nutrition:	

Please check any of the following that has been a problem for your child		
Blood problems	***Gastrointestinal***	***Neurological***
❑ Anemia	❑ Digestive disorder	❑ Headaches
❑ Bleeding disorder	❑ Liver or gall-bladder trouble	❑ Seizures or convulsions
❑ Blood pressure	❑ Ulcers	❑ Dizzy spells or fainting
❑ Other (specify)	❑ Other (specify)	❑ Numbness or paralysis
Cardiovascular	***Genitourinary***	❑ Head trauma/concussion
❑ Heart disease or murmur	❑ Kidney trouble or stones	❑ Other (specify)
❑ High blood pressure	❑ Bladder trouble	***Respiratory***
❑ Circulatory disorder	❑ Bed wetting	❑ Shortness of breath
❑ Other (specify)	❑ Other (specify)	❑ Asthma
Endocrine-Metabolic	***Gynecologic (Females only)***	❑ Other (specify)
❑ Thyroid	Date of last menstrual period:	***Skin***
❑ Diabetes	Is your child pregnant?	❑ Chronic or unexplained rash
❑ Other (specify)	❑ Other (specify)	❑ Hives or skin allergy
Eyes	***Musculoskeletal***	❑ Other (specify)
❑ Difficulty with vision	❑ Arthritis	***Throat***
❑ Wear glasses or contacts	❑ Joint problems	❑ Difficulty swallowing
❑ Other (specify)	❑ Fractures	❑ Other (specify)
Hematology/Oncology	❑ Other (specify)	
❑ Cancer		
❑ Other (specify)		

I have reviewed this Physical Health Screening

Print forms

Provider's Signature: _____ Date: _____ Time: _____