

Instructions for the

CHILD OR ADOLESCENT COMPREHENSIVE HISTORY AND QUESTIONNAIRE FORMS

The FREE Mental Health Screening Forms contain the Child/Adolescent Comprehensive History and the Child/Adolescent Questionnaire. The information collected in these documents can greatly aid your health care professional in conducting a comprehensive mental health assessment.

While this process may seem like a lot of work, your and your child's participation gives your clinician the information necessary to provide your child with the best diagnostic assessment possible.

The process will require an hour or more of your and your child's time. We realize that some questions may not apply to very young children, such as drug and alcohol use or driving too fast, but please answer as accurately and completely as possible. If you need more space, you can use the back of the assessment forms.

The child and adolescent symptom questionnaire can be filled out, with parental help, by children as young as 5 or 6 years old. Just read the question to your child and fill in the answer. Go slowly, one page or even one-half page at a time. Take frequent breaks. You will be surprised how much your child can tell you.

Some of the questions will seem quite personal; but it is important that they be answered completely. Your health care professionals may wish to share this information with others involved in your child's care. You need to know that they may not release any information about your child without your written permission.

No one has a perfect memory; but do the best you can in answering the questions accurately. **It is especially important to have approximate dates for any previous treatment.** For any psychiatric medication that has been taken, start and stop dates as well as dosages are needed. Month and year will do in most cases.

Try your best; most clinicians don't expect perfection, but remember that the information you give your clinician determines your child's treatment. You and your child are the most important members of your health care team.

You will notice that the instructions on the questionnaire ask **if your child has ever had any of the symptoms listed**. Psychiatric symptoms will come and go, so it is important to try to remember if your child has ever had symptoms. After you fill out each page, you and your child should **go back through the symptoms and circle the number that corresponds to symptoms your child is presently experiencing**.

For example on Page 1, #1

Parent Questionnaire

"My child feels discouraged a lot."

If your child/adolescent has ever felt discouraged in the past, you would **mark the appropriate box** for the degree of difficulty she or he has ever had: **Never, Not at all — Sometimes, Just a little — Often, Pretty much — Frequently, Very much.**

If your child/adolescent is feeling discouraged **at this time**, you would indicate this by **Circling the number 1**. The same is true for each question on every page of both the parent and child/adolescent forms.

CHILD OR ADOLESCENT COMPREHENSIVE HISTORY

Child's Name _____ Date _____

Child's Birth Date _____ Age _____ Referred by _____

Child's Address _____

Informant _____ Home Phone _____ Work Phone _____

Child's School _____ Grade _____

Family

Father's Name _____ Occupation _____ Age _____

Mother's Name _____ Occupation _____ Age _____

Stepfather's Name _____ Occupation _____ Age _____

Stepmother's Name _____ Occupation _____ Age _____

Brothers and Sisters Name _____ Age _____ Gender (M or F) _____

Name _____ Age _____ Gender (M or F) _____

Name _____ Age _____ Gender (M or F) _____

Name _____ Age _____ Gender (M or F) _____

Name _____ Age _____ Gender (M or F) _____

Name _____ Age _____ Gender (M or F) _____

Name _____ Age _____ Gender (M or F) _____

If parents are separated or divorced, address and phone numbers of other parent

Name _____ Home Phone _____ Work Phone _____

Address _____

Other persons residing in the home

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Healthcare

Company Health Benefits _____ Private Insurance _____ Medicaid _____ Medicare _____ Self-Pay _____

DEVELOPMENTAL HISTORY

Was the pregnancy planned? Yes ___ No ___ If there were any complications during the pregnancy, please explain.

Were you under emotional stress during the pregnancy? Yes ___ No ___ If yes, what was stressful? _____

Did you use: Drugs _____ Alcohol _____ Tobacco _____ Medications _____

If yes to any of the above, please give the type, amounts used, and frequency during the pregnancy _____

Were you involved in prenatal care? Yes _____ No _____ Birth weight of child _____

Any difficulties with the birth? Please explain _____

Did your baby have to stay in the hospital after the birth? Yes ___ No ___ If yes, why? _____

For the next questions if you do not remember an approximate time, please check *Before or After?*

When did your child walk? _____ Before ___ After ___ one year?

Say his/her first word? _____ Before ___ After ___ one year?

Talk in sentences? _____ Before ___ After ___ three years?

Complete toilet training? _____ Before ___ After ___ three years?

Were there any speech problems? _____

Has your child had speech therapy? _____

EARLY CHILDHOOD PROBLEMS

Were there early difficulties during infancy with Feeding Sleeping Colic Head banging Excessive Rocking?

Were there any early problems (before age 7) with the following?

Nightmares Night terrors Bed wetting Messing pants Unusual fears Aggression Temper tantrums

Hyperactivity Difficulties with impulse control Inability to pay attention Problems with other children

Being a dare devil Having no fear Being bold Being demanding Being overly sensitive

If yes to any of the above early childhood problems, please explain _____

For the following questions, please indicate dates and how long the abuse lasted.

Has your child ever been physically abused? _____

Sexually abused? _____

Psychologically abused? _____

SCHOOL

Has your child experienced any difficulties in school? Academic _____ Behavioral _____

Has your child been suspended from school? _____ How many times _____ When _____

Has your child been expelled from school? _____ When _____ For how long _____

Does your child have a learning disability? Please explain. _____

SCHOOL PERFORMANCE

Extremely Important:

1. Please fill in the ESTIMATED average grades for each school year.
 - Average Grades by Year (S = Satisfactory, U = Unsatisfactory, Letter Grades = A, B, C, D, F)
2. Please Explain Any Behavioral or Academic Problems For Each Year
 - Example of problems (Would not sit down, could not follow directions, cut class, etc.)

<u>Example</u>	<u>My Child's Averages</u>	<u>Problems during the year</u>
↓	↓	↓
S <u>K</u>	Average _____	Problems _____
S <u>1st Grade</u>	Average _____	Problems _____
U <u>2nd Grade</u>	Average _____	Problems _____
S <u>3rd Grade</u>	Average _____	Problems _____
B <u>4th Grade</u>	Average _____	Problems _____
C <u>5th Grade</u>	Average _____	Problems _____
C <u>6th Grade</u>	Average _____	Problems _____
D <u>7th Grade</u>	Average _____	Problems _____
F <u>8th Grade</u>	Average _____	Problems _____
D <u>9th Grade</u>	Average _____	Problems _____
C <u>10th Grade</u>	Average _____	Problems _____
D <u>11th Grade</u>	Average _____	Problems _____
F <u>12th Grade</u>	Average _____	Problems _____

POSITIVES ABOUT YOUR CHILD

Please list positives about your child (for example, good with children, athletic, musical, etc.) _____

CHILD'S ACTIVITIES

What does your child like to do for fun? _____

TREATMENT EXPECTATIONS

Please list your expectations concerning the outcome of treatment for your child. _____

ENVIRONMENTAL STRESSORS

Have there been major changes or events in your child or family's life? Please elaborate.

Death of friend or family member _____

Moves _____

Significant medical problems for child _____

Ill health of family member _____

Financial problems _____

Abuse in family _____

Addiction in family _____

Violence in family _____

Other _____

CHILD'S MEDICAL HISTORY

Has your child ever experienced any of the following? Please explain.

Major medical problems _____

Seizures _____

Medical Hospitalization _____

Psychiatric Hospitalization _____

Attempted suicide _____

Head injuries _____

Prolonged fevers _____

Serious infections _____

Surgeries _____

Broken bones _____

Asthma _____

Allergies _____

Medication allergies _____

If female, last menstrual period _____ Has your child ever been pregnant? _____ If yes, age _____

Is your child currently taking any medications? Please list with dosages.

Immunizations current? Yes ___ No ___ If not, which are lacking? _____

LEGAL HISTORY

Please list all present and past legal charges your child has experienced giving dates of offenses _____

Please list times in detention and for what offenses _____

Please give name of your child's present probation officer _____

Please list legal difficulties family members have experienced _____

