

List other important people in your child's life (e.g., siblings, grandparents, etc.) who are not living in the home:

Name	Age	Relationship

Describe the main reasons, questions, or concerns for having your child evaluated at this time:

Please check all the concerns about your child:

<input type="checkbox"/> Anxiety, nervousness, worry, fears	<input type="checkbox"/> Hyperactivity/impulse control	<input type="checkbox"/> Social/friendship concerns
<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Inattention, disorganization	<input type="checkbox"/> Bullying
<input type="checkbox"/> Obsessive compulsive behaviors	<input type="checkbox"/> Forgetfulness, memory problems	<input type="checkbox"/> Alcohol/drug issues
<input type="checkbox"/> Depression, moodiness	<input type="checkbox"/> Academic struggles	<input type="checkbox"/> Sexual behavior concerns
<input type="checkbox"/> Aggression	<input type="checkbox"/> Learning difficulties	<input type="checkbox"/> Sleep problems
<input type="checkbox"/> Oppositional/defiant behavior	<input type="checkbox"/> School attendance/refusal	<input type="checkbox"/> Eating/weight concerns
<input type="checkbox"/> Breaking rules or laws, legal issues	<input type="checkbox"/> Sensory concerns (over/under reactivity to pain, lights, touch, sound, textures, etc)	<input type="checkbox"/> Headaches, stomach aches, or aches/pains
<input type="checkbox"/> Hallucinations (hearing voices, seeing things)	<input type="checkbox"/> Other behavioral/emotional issues:	

How long have these concerns been present? What has been done so far to address these concerns?

Do you have any concerns or issues that are not appropriate to discuss in your child's presence, including those you have already listed in this questionnaire? If yes, please indicate:

Please check any family changes or stressors that your child has experienced:

<input type="checkbox"/> Moves	<input type="checkbox"/> Parental conflict	<input type="checkbox"/> Violence
<input type="checkbox"/> Separation or divorce	<input type="checkbox"/> Emotional abuse	<input type="checkbox"/> Health issues for family members
<input type="checkbox"/> Remarriage of parent	<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Death
<input type="checkbox"/> Family member leaving the home	<input type="checkbox"/> Sexual abuse	<input type="checkbox"/> Legal problems
<input type="checkbox"/> New family member living in home	<input type="checkbox"/> Neglect	<input type="checkbox"/> Incarceration
<input type="checkbox"/> Job changes	<input type="checkbox"/> Other family changes or stressors:	

What are your child's specific needs for treatment at this time? What help are you hoping that your child will receive?

Please list your child's personal strengths and resources that help your child cope with stress (e.g., family support, stable living situation, education, faith, prior response to treatment, etc):

Please list any difficulties with being able to regularly attend scheduled treatment appointments (e.g., school schedule, work schedule, childcare, transportation, etc):

PREVIOUS PSYCHIATRIC TREATMENT HISTORY:

Has your child ever seen a counselor or any healthcare professional for an emotional problem?

Yes No If yes, please complete the following:

Dates of treatment	Diagnosis/reason for treatment	Name of provider and/or institution (clinic, hospital, etc)

Has your child ever been hospitalized for psychiatric reasons? Yes No

Has your child ever been suicidal? Yes No If yes, was there an attempt? Yes No

Has your child ever engaged in self-harm behaviors? Yes No

Please list current and past psychiatric medications that your child has taken:

Dates of treatment	Medication	Current / Past (Please Circle)	Name of prescribing provider
		Current / Past	
		Current / Past	
		Current / Past	
		Current / Past	

MEDICAL/DEVELOPMENTAL HISTORY:

Child's Pediatrician/Family Practitioner: _____

Name of clinic and address: _____ Clinic phone number: _____

Please check all the concerns/events that applied to pregnancy, labor and delivery with this child:

<input type="checkbox"/> Limited/no prenatal care	<input type="checkbox"/> Use of alcohol/drugs in pregnancy	<input type="checkbox"/> Premature baby
<input type="checkbox"/> Use of medication during pregnancy	<input type="checkbox"/> Physical abuse during pregnancy	<input type="checkbox"/> Late term baby
<input type="checkbox"/> Use of tobacco during pregnancy	<input type="checkbox"/> Low birth weight	<input type="checkbox"/> NICU care
<input type="checkbox"/> Mother illness (please specify):		
<input type="checkbox"/> Birth complications: <input type="checkbox"/> Difficult labor <input type="checkbox"/> Induced <input type="checkbox"/> Breech <input type="checkbox"/> Emergency C-section <input type="checkbox"/> Forceps <input type="checkbox"/> Other:		

Please check any areas that were of concern during infancy with this child:

<input type="checkbox"/> Lactation/feeding	<input type="checkbox"/> Sleep	<input type="checkbox"/> Bonding
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Colic/fussy baby	<input type="checkbox"/> Postpartum depression or anxiety

Approximately how old was your child when he/she was able to:

Milestone behavior	Age in months or years	Please circle		
Sit without help		Early	Average	Late
Walk without help		Early	Average	Late
Speak 5 words		Early	Average	Late
Speak in sentences		Early	Average	Late
Stay dry all day		Early	Average	Late
Stay dry all night		Early	Average	Late

Please check any medical concerns you may have for your child:

<input type="checkbox"/> Head injuries/concussions	<input type="checkbox"/> Bowel or bladder problems	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Seizures	<input type="checkbox"/> Headaches or migraines	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Vision or hearing problems	<input type="checkbox"/> Stomach aches	<input type="checkbox"/> Allergies
<input type="checkbox"/> Chronic ear infections	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Asthma or breathing problems
<input type="checkbox"/> Surgeries	<input type="checkbox"/> Hospitalizations	<input type="checkbox"/> Other:

Please list any current prescribed medications, over the counter medications, vitamins, herbal supplements, and/or remedies that your child may be taking. Please do not re-list current psychiatric medications.

Date started	Medication name

FAMILY MEDICAL/PSYCHIATRIC HISTORY:

Please check any medical and psychiatric conditions in other blood relative family members. Please circle **P** for paternal side and **M** for maternal side of the family where indicated:

CONDITION	FATHER	MOTHER	BROTHER	SISTER	GRANDFATHER	GRANDMOTHER	UNCLE	AUNT	COUSIN(S)	OTHER <i>(Please indicate)</i>
Alcoholism/substance abuse					P M	P M	P M	P M	P M	
Anxiety					P M	P M	P M	P M	P M	
Depression					P M	P M	P M	P M	P M	
Suicide attempts					P M	P M	P M	P M	P M	
Bipolar					P M	P M	P M	P M	P M	
Schizophrenia					P M	P M	P M	P M	P M	
Autism					P M	P M	P M	P M	P M	
Cognitive challenges or delays					P M	P M	P M	P M	P M	
Physical/emotional abuse					P M	P M	P M	P M	P M	
Sexual abuse					P M	P M	P M	P M	P M	
Eating disorders					P M	P M	P M	P M	P M	
Learning problems					P M	P M	P M	P M	P M	
Attention problems					P M	P M	P M	P M	P M	
Seizure disorder					P M	P M	P M	P M	P M	
Thyroid disease					P M	P M	P M	P M	P M	
Other:					P M	P M	P M	P M	P M	

CHILD AND FAMILY SUBSTANCE USE:

How often does your child use the following substances?

	Never	Daily	Several times per week	Few times per month	Few times per year
Nicotine					
Alcohol					
Marijuana					
Caffeine, energy drinks					
Other drugs					
Please list other drugs:					

Please note how often parents/stepparents/caregivers use the following substances:

	Never	Daily	Several times per week	Few times per month	Few times per year
Nicotine					
Alcohol					
Marijuana					
Other drugs					
Please list other drugs:					

Please list any parents/stepparents/caregivers/former partners who have ever had any alcohol, drug, or prescription medication problems:

Relationship to your child	Type of problem (if known)

ACADEMIC/SCHOOL HISTORY:

Please indicate how your child has performed academically at school, and how your child has gotten along with teachers, neighbors, and other children at school or in the neighborhood. Please summarize information from parent-teacher conferences, your own observations, comments from others, etc. Feel free to use the last page or back of page if needed.

GRADE	ACADEMIC CONCERNS	SOCIAL/PEER CONCERNS	ADDITIONAL SERVICES <i>(OT/PT, Speech/Language, Special Education, IEP)</i>
Infancy – Preschool (0–3)			
KG – 5th Grade			
6th – 8th Grade			
9th – 12th Grade			