

CHILD AND ADOLESCENT EVALUATION QUESTIONNAIRE

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Name of Patient _____ Date _____

Date of Birth _____ Sex _____ Home Phone Number _____

Address _____
Street City State Zip

Patient's cell phone number _____ E-Mail _____

Father's Name _____ Age _____

Father's Occupation _____ Work phone # _____ Cell phone # _____

Mother's Name _____ Age _____

Mother's Occupation _____ Work phone # _____ Cell phone # _____

Mother's E-Mail _____ Father's E-Mail _____

If divorced or separated name, ex-spouse's name or significant other's name _____

Child's current school _____

School Address _____

Name of Authorized School Informant _____

Referral Source _____ Phone # _____

Pediatrician _____ Phone # _____

Pediatrician's address _____
Street City State Zip

FAMILY CONSTELLATION

Does your child live with both natural parents? Yes No

If no please describe your child's living situation and visitation arrangements including other adults or children involved in these arrangements. Please include names and ages of siblings and half and/or step siblings. _____

LIFE STRESSORS: (Please include any significant deaths, separations, moves, accidents, traumatic events, parent lost or changed job, changed schools, family financial problems)

PURPOSE OF THE EVALUATION/ CURRENT BEHAVIORAL CONCERNS:

What strategies have been implemented to address these problems? (Please check which have been used and note if successful)

Verbal reprimands _____ Time out _____

Removal of privileges _____ Rewards _____

Physical punishment _____ Acquiescence to child _____

Avoidance of child _____ Other _____

On the average, what percentage of the time does your child comply with initial commands?

0-20% _____ 20-40% _____ 40-60% _____ 60-80% _____ 80-100% _____

On the average, what percentage of the time does your child eventually comply with commands?

0-20% _____ 20-40% _____ 40-60% _____ 60-80% _____ 80-100% _____

To what extent are you and your spouse consistent with respect to disciplinary strategies?

Most of the time _____ Some of the time _____ None of the time _____

PSYCHOLOGICAL TREATMENT Has your child had any of the following forms of psychological treatment? If so, how long did it last? (Please check all that apply)

Individual psychotherapy _____ Duration of Therapy _____

Group psychotherapy _____ Duration of Therapy _____

Family Therapy _____ Duration of Therapy _____

Inpatient Evaluation/RX _____ Duration of Inpatient Stay _____

Residential Treatment _____ Duration of placement _____

Please give additional elaboration on name of facility and cause/precipitating event of any hospitalization. _____

_____.

List all Medications your child is currently taking:

DRUG	DOSE	START DATE
• _____		
• _____		
• _____		
• _____		
• _____		
• _____		
• _____		
• _____		
• _____		
• _____		
• _____		

What are the names and phone numbers of the physicians who are prescribing the medications?

Name _____ Phone Number _____

Which Medications? _____

Name _____ Phone Number _____

Which Medications? _____

Please describe if there are side effects (even if you are not sure if they are side effects):

DEVELOPMENTAL HISTORY: (Prenatal, labor, delivery and peri-natal)

Age of mother at baby's birth _____ Age of father at baby's birth _____

Number of full term pregnancies, abortions or miscarriages and approximate dates: _____

_____.

How was the mother's health during pregnancy? _____

Do you recall using any of the following substances or medications during pregnancy?

Beer or Wine

- ___ never ___
- ___ once or twice ___ once
- ___ 3-9 times ___ 3-9
- ___ 10-19 times ___ 10-19
- ___ 20-39 time ___ 20-39
- ___ 40+ times ___

Hard liquor

- never
- or twice
- times
- times
- times
- 40+ times

Coffee or other caffeine (coke, etc.)

Taken together, how many times?

- ___ never ___
- ___ once or twice ___ once
- ___ 3-9 times ___ 3-9
- ___ 10-19 times ___ 10-19
- ___ 20-39 time ___ 20-39
- ___ 40+ times ___

Cigarettes _____

- never
- or twice
- times
- times
- times
- 40+ times

Did you take any medications during pregnancy? _____yes _____no

If yes, which medications did you take? (please include over the counter medications as well as all prescriptions)_____

Did you develop diabetes during the pregnancy? _____yes _____no

Did you develop toxemia, pre-eclampsia or eclampsia? _____yes _____no _____not sure

Was it a full term pregnancy? ___yes ___no

Was it a breach delivery? ___yes ___no

Was it a forceps delivery? ___yes ___no

Was there meconium present at delivery? ___yes ___no

Was an epidural used during delivery? _____yes _____no

Were any medications used during delivery? _____yes _____no

Was the baby delivered by c-section? _____ yes _____no

What was the baby's birth weight? _____lbs

How much weight did the mother gain? _____

How long did the baby remain in the hospital after delivery? _____days

If longer than 2 days, please state the reason. _____

Were there problems with the infant's responsiveness (alertness)? _____yes _____no _____not sure

What was the Apgar score? _____not sure

Did your child experience any health problems during infancy? _____yes _____no _____not sure

DEVELOPMENTAL MILESTONES

Did your child have any congenital problems? [] yes [] no

If so, please describe _____

Please check one answer for each of the following questions.

1. Was your child an easy baby? (By that I mean did (s)he cry a lot? Did (s)he follow a schedule fairly well?) very easy easy average difficult very difficult

2. How did the baby behave with other people?
 more social than average average sociability more sociable than average

3. When (s)he wanted something, how insistent was (s)he?
 very insistent pretty insistent average
 not very insistent not insistent at all

4. How would you rate the activity level of your child as an infant?
 very active active average less active not active

5. At what age did (s)he smile socially? 2 months 3 months 4 months or more

6. At what age did (s)he sit up? 3-6 months 7-12 months over 12 months

7. At what age did (s)he crawl? 6-12 months 13-18 months over 18 months
 not sure

8. At what age did (s)he walk? under one year 1-2 years 2-3 years not sure

9. At what age did (s)he speak single words (other than “mama” or “dada”)
 9-13 months 14-18 months 19-24 months
 25-36 months 37-48 months not sure

10. Did your child develop stranger anxiety? yes no

11. If so, how severe? severe moderate mild

12. If so, at what age? _____ months

13. Did your child have any separations from her/his mother for over a week before the age of 2 years old? yes no

If so, for how long? _____ What were the reasons? _____

14. Has your child had any accidents resulting in the following? (Please check all that apply)
 broken bones severe lacerations head injury severe bruises
 stomach pumped eye injury lost teeth sutures
 other, please specify _____

15. How many accidents has your child had? one 2-3 4-7 8-12 more than 12

16. Has your child had any severe illnesses and at what age? _____
Was your child hospitalized yes no Please elaborate if yes. _____

17. Has your child had surgery for any of the following? (check all that apply)
 Tonsillitis Adenoids Hernia Appendicitis Eye, ear, nose or throat
 Digestive disorders Urinary tract Leg or Arm Problems
 other _____

18. Please specify number of hospitalizations and length of each stay. _____
_____.

19. Does your child have trouble sleeping?
 none difficulty falling asleep sleep continuity disturbance
 early morning awakening

20. Is your child a restless sleeper? yes no not sure

21. Does your child have bladder control problems.....at night? yes no
If yes, how often? _____
If yes, was (s)he ever continent _____
.....during the day? yes no
If yes, how often? _____
If yes, was (s)he ever continent _____

22. Does your child have bowel control problems.....at night yes no
If yes, how often? _____
If yes, was (s)he ever continent _____
.....during the day? yes no
If yes, how often? _____
If yes, was (s)he ever continent _____

23. Does your child have any appetite control problems?
 over-eater average under-eater

(For Adolescents only)

Is there any use of drugs, alcohol or nicotine? _____ Yes _____ No _____ Not sure

If yes, please explain briefly _____

_____.

Is there any history of physical/sexual abuse? _____ Yes _____ No _____ Not sure

If yes, please explain briefly _____
_____.

FAMILY HISTORY...MOTHER

Age _____ Fertility problems (specify) _____

Education: Highest Grade Completed _____

Learning Problems (specify) _____ Grade Repeat _____

Behavior Problems (specify) _____

Medical Problems (specify) _____

Have any of your blood relatives (not including patient or his/her siblings) ever had problems similar to those your child has? _____ If so, please describe: _____

MOTHER OF PATIENT AND MATERNAL RELATIVES

	Self	Mother	Father	Brother	Brother	Sister	Sister
Problems with aggressiveness, defiance, & oppositional behavior as a child							
Problems with attention, over-activity, and impulse control as a child							
Learning Disabilities							
Failed to graduate from high school							
Cognitive Delays							
Psychosis or schizophrenia							
Depression for greater than two weeks							
Anxiety Disorder that impaired adjustment							
Tics or Tourette's Syndrome							
Alcohol abuse							
Substance abuse							
Anti-social behavior (assaults, thefts, etc.)							
Arrests							
Physical abuse							
Sexual abuse							

FAMILY HISTORY... FATHER

Age _____ Age at time of the patient's conception _____

Fertility problems _____

Education: Highest Grade Completed _____

Learning Problems (specify) _____ Grade Repeat _____

Behavior Problems (specify) _____

Medical Problems (specify) _____

Have any of your blood relatives (not including patient or his/her siblings) ever had problems similar to those your child has? _____ If so, please describe: _____

FATHER OF PATIENT AND PATERNAL RELATIVES

	Self	Mother	Father	Brother	Brother	Sister	Sister
Problems with aggressiveness, defiance, & oppositional behavior as a child							
Problems with attention, over-activity, and impulse control as a child							
Learning Disabilities							
Failed to graduate from high school							
Cognitive Delays							
Psychosis or schizophrenia							
Depression for greater than two weeks							
Anxiety Disorder that impaired adjustment							
Tics or Tourette's Syndrome							
Alcohol abuse							
Substance abuse							
Anti-social behavior (assaults, thefts, etc.)							
Arrests							
Physical abuse							
Sexual abuse							

SIBLINGS OF PATIENT

Brother		Brother	Brother	Sister	Sister	Sister
Siblings' Names						
Problems with aggressiveness, defiance, & oppositional behavior as a child						
Problems with attention, over-activity, and impulse control as a child						
Learning Disabilities						
Failed to graduate from high school						
Cognitive Delays						
Psychosis or schizophrenia						
Depression for greater than two weeks						
Anxiety Disorder that impaired adjustment						
Tics or Tourette's Syndrome						
Alcohol abuse						
Substance abuse						
Anti-social behavior (assaults, thefts, etc.)						
Arrests						
Physical abuse						
Sexual abuse						

EDUCATIONAL HISTORY

Please summarize your child's progress (e.g. academic, social, testing) within each of these grade levels.

Preschool _____

Kindergarten _____

Grades 1 through 3 _____

Grades 4 through 6 _____

Grades 7 through 12 _____

Has your child ever been in any type of special education program and if so how long?

Learning Disabilities Class _____ **Duration of placement** _____

Behavioral /Emotional disorder class _____ **Duration of placement** _____

Resource Room _____ **Duration of placement** _____

Speech & Language Therapy _____ **Duration of therapy** _____

Other (specify) _____ **Duration of program** _____

Was your child ever?

1. Suspended from school? **Yes** **No** **Number of suspensions** _____

2. Retained in grade? **Yes** **No** **Number of retentions.** _____

3. Expelled from school? **Yes** **No** **Reason for expulsion** _____

Have any additional instructional modifications been attempted? (check all that apply)

None _____ **Behavior Modification program** _____ **Daily/weekly report card** _____

Other (please specify) _____

SOCIAL HISTORY

Does your child get along with his /her brothers and sisters? _____

How easily does your child make friends? _____

How many friends does your child have? _____

On the average, how long does your child keep friendships? _____

Does your child see friends after school and/or on weekends? _____

Which of the following are considered to be significant problems at the present time?

(Check all that apply)

- Fidgets _____
- Difficulty remaining seated _____
- Easily Distracted _____
- Difficulty waiting turn _____
- Often blurts out answers to questions before questions are completed _____
- Difficulty following instructions _____
- Difficulty sustained attention _____
- Shifts from one activity to another _____
- Difficulty playing quietly _____
- Often talks excessively _____
- Often interrupts or intrudes on others _____
- Often does not listen _____
- Often loses things _____
- Often engages in physically dangerous activities _____

When did these problems begin (specify age) _____

(Continued on following page)

Which of the following are considered to be significant problems at the present time?

(Check all that apply))

Often loses temper ___

Often argues with adults ___

Often actively defies or refuse adult requests
or rules ___

Often deliberately does things that annoy
other people ___

Often blames others for own mistakes ___

Is often touchy or easily annoyed by others ___

Is often angry or resentful ___

Is often spiteful or vindictive ___

Often swears or uses obscene language ___

Ran away from home overnight at least twice ___

Lies often ___

Cruel to animals ___

Unrealistic and persistent worry about possible
harm to parents and siblings. ___

School refusal ___

Refusal to sleep alone ___

Avoidance of being alone ___

Repeated nightmares re: separation ___

Bodily complaints or concerns ___

Excessive distress in anticipation of or actual
Separation from parents ___

Marked nervousness ___

Unrealistic worries about future events ___

Marked self-consciousness ___

Excessive need for reassurance ___

Marked inability to relax ___

Depressed or irritable mood most of the day,
nearly every day ___

Diminished pleasure in activities ___

Insomnia or hypersomnia nearly every day ___

Fatigue or loss of energy ___

Feelings of worthlessness or excessive ___

Inappropriate guilt ___

Suicidal ideation or attempt ___

Low self esteem ___

Poor concentration or difficulty making
decisions ___

Feelings of hopelessness ___

When did these problems begin? (specify age) _____

CHILDREN'S ATYPICAL DEVELOPMENT SCALE (CADS)

Below is a list of behaviors. For each item, please circle two if the item is very true or often true of your child. Circle 1 if the item is somewhat or sometimes true. If the item is not true of your child circle 0. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = NOT TRUE 1 = SOMEWHAT OR SOMETIMES TRUE 2 = VERY TRUE OR OFTEN TRUE

- | | | | |
|---|---|---|---|
| 0 | 1 | 2 | 1. "Misses the point" or main idea in conversation. |
| 0 | 1 | 2 | 2. Rambling speech- one idea is not connected to the next. |
| 0 | 1 | 2 | 3. Refers to self in the third person (e.g. uses own name instead of I or me) |
| 0 | 1 | 2 | 4. Makes odd noises/talks in odd voices. |
| 0 | 1 | 2 | 5. Obsessive interest in narrow or atypical topic or even (e.g., death, the supernatural, anatomy, fantasy characters) |
| 0 | 1 | 2 | 6. Makes irrelevant comments. |
| 0 | 1 | 2 | 7. Insists on sticking to unusual routines. |
| 0 | 1 | 2 | 8. Lacks interest in toys or uses toys in unusual way. |
| 0 | 1 | 2 | 9. Strong attachments to inanimate objects. |
| 0 | 1 | 2 | 10. Unusual aversions to neutral objects or situations (e.g., will not wear certain materials, refuses to walk up a certain stairway) |
| 0 | 1 | 2 | 11. Engages in repetitive or stereotypic behavior (e.g., shakes or flaps hands, repeatedly touched hair or other material.) |
| 0 | 1 | 2 | 12. Extreme reactions to minor inconveniences or irritations. |
| 0 | 1 | 2 | 13. Difficulties dealing with change in daily schedule or routines. |
| 0 | 1 | 2 | 14. Marked lack of concern about appearance. |
| 0 | 1 | 2 | 15. Lacks social discretion (e.g. comments on people's behavior in public without concern for their reaction or feelings.) |
| 0 | 1 | 2 | 16. Acts as if other people were not in the same room. |
| 0 | 1 | 2 | 17. Poor judge of other people's reactions or feelings. |
| 0 | 1 | 2 | 18. Reveals overly personal detail to acquaintances or strangers. |
| 0 | 1 | 2 | 19. Lacks interest in peers. |
| 0 | 1 | 2 | 20. Makes poor eye contact with others. |
| 0 | 1 | 2 | 21. Does not appreciate personal space (e.g., stands too close or talks with Back to person) |
| 0 | 1 | 2 | 22. Mood changes quickly without apparent reason. |
| 0 | 1 | 2 | 23. Describes the details of an event but misses the meaning or importance of it. |
| 0 | 1 | 2 | 24. Sits, stands or walks in odd postures. |
| 0 | 1 | 2 | 25. Attributes meaning to events that are simply a coincidence. |
| 0 | 1 | 2 | 26. Believes others are talking about him/her when others are speaking softly among themselves. |
| 0 | 1 | 2 | 27. Overly suspicious of others. |
| 0 | 1 | 2 | 28. Confuses the sequence in which events occurred when describing them. |
| 0 | 1 | 2 | 29. Lacks compassion when others are hurt or finds it humorous. |
| 0 | 1 | 2 | 30. Laughs or cries for little apparent reason. |

- | | | | |
|---|---|---|--|
| 0 | 1 | 2 | 31. Attends to background or distant sound that others would ignore.
(continued on next page) |
| 0 | 1 | 2 | 32. Excessively preoccupied with violent stores, TV shows or weapons. |
| 0 | 1 | 2 | 33. Confuses the causes of events or fails to understand how events cause other events. |
| 0 | 1 | 2 | 34. Draws excessively detailed pictures. |
| 0 | 1 | 2 | 35. Dislikes being held or touched. |
| 0 | 1 | 2 | 36. Keeps a diary or journal of rambling thoughts or random ideas. |
| 0 | 1 | 2 | 37. Speaks in half-thought or incomplete phrases without concern for whether others can understand or follow his/her ideas. |
| 0 | 1 | 2 | 38. Gets angry for little apparent reason. |
| 0 | 1 | 2 | 39. Has unusual fears not typical for his/her age group (e.g., afraid to take shower or put head under the water after 6 years of age. |
| 0 | 1 | 2 | 40. Hoards worthless objects that have no apparent meaning or value. |
| 0 | 1 | 2 | 41. Speaks in excessively loud or soft voice. |
| 0 | 1 | 2 | 42. Overreacts to pain (e.g., bumps leg and screams and cries excessively) |
| 0 | 1 | 2 | 43. Exhibits ritualistic behaviors (e.g. has to line up toys in a particular order after using the. |
| 0 | 1 | 2 | 44. Spends an unusual amount of time fantasizing. |
| 0 | 1 | 2 | 45. Mouths or chews objects. |
| 0 | 1 | 2 | 46. Seems to be extremely naïve for his/her age (e.g., believes anything he/she is told. |
| 0 | 1 | 2 | 47. Does not respond to the initiations of other children. |
| 0 | 1 | 2 | 48. Picks nose, skin, or other parts of the body. |
| 0 | 1 | 2 | 49. Makes bizarre statements. |
| 0 | 1 | 2 | 50. Interacts with acquaintances and strangers in a similar manner. |
| 0 | 1 | 2 | 51. Hits or bites self. |
| 0 | 1 | 2 | 52. Repeats certain acts over and over. |
| 0 | 1 | 2 | 53. Lacks modesty for his/her age. |

TEMPERMENTAL TRAITS

(PLEASE CIRCLE ALL THOSE THAT APPLY)

- | | | |
|--|--|---|
| 1. Bodily complains: hypochondriasis | 20. Arrogance | 38. Suspicious (marked) or <u>intense</u> jealousy. |
| 2. Dissatisfaction (chronic) or lack of pleasure | 21. Boastfulness | 39. Eccentric |
| 3. Easy fatigability | 22. Distractibility. | 40. Excessively reserved. |
| 4. Guilt over minor indiscretions. | 23. Extraverted; very "out-going" | 41. "Loner" |
| 5. Indecisiveness. | 24. Heightened self confidence; over-optimism, mild euphoria | 42. Self-consciousness (severe) |
| 6. Inordinate examination fear. | 25. Hyper-sexuality or promiscuity(for adolescents) | 43. Shyness (moderate to extreme) |
| 7. Joylessness. | 26. Insensitivity or coarseness | 44. Superstitious |
| 8. Lack of initiative | 27. Lack of insight | 45. Unsociable. |
| 9. Pessimism | 28. Over-spending. | 46. Withdrawn |
| 10. Self doubt: excessive worrying | 29. Stubbornness | 47. Overly sensitive. |
| 11. Terrifying dreams | 30. Taking too much, or too loud. | |
| 12. Abusiveness | 31. Teasing others inordinately | |
| 13. Heightened premenstrual irritability. | 32. Blames others. | |
| 14. Impulsivity | 33. Grudge-holding; unforgiving. | |
| 15. Irritability | 34. Humorless. | |
| 16. Jealousy | 35. Hypercritical of others. | |
| 17. Mildly irascible | 36. Quarrelsome. | |
| 18. Opinionated; dogmatic | 37. Resentful | |
| 19. Alcoholism | | |