CHILD AND ADOLESCENT EVALUATION QUESTIONAIRE

Howard S. Rudominer, M.D. P. A.

59 Springbrook Road
Livingston, New Jersey 07039
973-716-9500

Today's Date _____ **Drug Allergies** _____

Name, Address and Phone number of Pharmacy _____

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**_____ **E-Mail**_____

Father's Occupation_____**Work phone #**_____**Cell phone #**_____

Mother's Name_____**Age**_____ **E-Mail**_____

Mother's Occupation_____**Work phone #**_____**Cell phone #**_____

Stepfather's Name_____**Age**_____ **E-Mail**_____

Stepfather's Occupation_____**Work phone #**_____**Cell phone #**_____

Stepmother's Name_____**Age**_____ **E-Mail**_____

Stepmother's Occupation_____**Work phone #**_____**Cell phone #**_____

Child's current school_____

School Address_____

Name of Authorized School Informant_____

Referral Source_____**Phone #**_____

Pediatrician_____ **Phone #**_____

Pediatrician's address_____
Street **City** **State** **Zip**

Siblings, Step-Siblings, Half-Siblings (Include names, ages, school, occupation):

_____

_____

_____

_____

_____

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.

_____

_____

_____

_____

_____

CHIEF COMPLAINT

PURPOSE OF THE EVALUATION/ CURRENT BEHAVIORAL CONCERNS:

_____

_____

_____

_____

HISTORY OF PRESENT ILLNESS - Describe when your child's symptom began and if it changed over time):

_____

_____

_____

_____

FAMILY AND SOCIAL HISTORY: _____

_____

_____

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

_____

_____

_____

_____

_____

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._____

_____

_____

What Diagnosis has your child been given by child's treating professional?:

_____

_____

List all Medications your child is currently taking (including psychiatric, medical and over the counter):

DRUG	DOSE	START DATE	CONDITION BEING TREATED

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Please describe if there are/were side effects to any of the psychiatric medications (even if you are not sure if they are side effects):

_____

_____

_____

_____

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

Name_____Phone Number_____

Which Medications?_____

_____

Name _____Phone Number _____

Which Medications?_____

_____

Name_____Phone Number_____

Which Medications?_____

_____

Name _____Phone Number _____

Which Medications?_____

_____

Name_____Phone Number_____

Which Medications?_____

_____

Name _____Phone Number _____

Which Medications?_____

_____

PAST PSYCHIATRIC HISTORY

Describe psychiatric history and other treatments for psychiatric or behavioral symptoms with dates of treatment. Include what diagnosis you were told your child had in the past or presently has now (IMPORTANT).

_____

_____

_____

_____

_____

_____

ADDITONAL INFORMATION

It would be very helpful to provide any additional personal history or relevant information in this section about your child's life not found in these specific questions.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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
__ 3-9 times
__ 10-19 times
__ 20-39 time
__ 40+ times

Hard liquor

__ never
__once or twice
__3-9 times
__10-19 times
__20-39 times
__ 40+ times

Coffee or other caffeine (coke, etc.)
Taken together, how many times?

__never
__ once or twice
__ 3-9 times
__ 10-19 times
__ 20-39 time
__ 40+ times

Cigarettes

__ never
__once or twice
__3-9 times
__10-19 times
__20-39 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

<u>DEVELOPMENTAL MILESTONES</u>

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_____

MEDICAL HISTORY

Primary Physician's Name:_____ **Physician's Phone No.**: _____
Doctor's Address:_____
Date of most recent physical examination._____

Have you ever been treated for any of the following?

	YES	***NO***	**COMMENTS (*TO BE ENTERED BY PSYCHIATRIST ONLY)***
Heart Disease			
High Blood Pressure			
Stroke			
Endocrine (including Diabetes)			
Arthritis or Other Bone Problems			
Neurological Problem/Parkinson's			
Cataracts/other eye problems			
Nose/Mouth/Throat			
Hearing Problems			
Lung/Respiratory Diseases			
Skin Diseases			
Urinary Problems			
Gastro-Intestinal			

Growths/Cancer
Hospitalizations
Major Operations
Sexually Transmitted Diseases
Kidney Disease
Liver Disease
Gynecologic Problems
Muscular Problems
Sexual Problems (incldg., STDs)
Other Medical Problems

Have you had?

Blackouts
Convulsions or Seizures
Headaches
Tremors
Dizziness
Forgetfulness
Major Weight Loss/Gain

Do you have a history of:
Drug Abuse
Alcohol Abuse

BRIEFLY DESCRIBE ANY CURRENT MEDICAL PROBLEMS

Has anyone in your family been treated for?

	YES	*NO*	**COMMENTS (*TO BE ENTERED BY PSYCHIATRIST ONLY)**
Heart Disease			
High Blood Pressure			
Stroke			
Endocrine (including Diabetes)			
Arthritis or Other Bone Problems			
Neurological Problem/Parkinson's			
Cataracts/other eye problems			
Nose/Mouth/Throat			
Hearing Problems			
Lung/Respiratory Diseases			
Skin Diseases			
Urinary Problems			
Gastro-Intestinal			
Growths/Cancer			

Hospitalizations _____
Major Operations _____
Sexually Transmitted Diseases _____
Kidney Disease _____
Liver Disease _____
Gynecologic Problems _____
Muscular Problems _____
Sexual Problems (incldg., STDs) _____
Other Medical Problems _____

Has anyone in your family had?

Blackouts _____
Convulsions or Seizures _____
Headaches _____
Tremors _____
Dizziness _____
Forgetfulness _____
Major Weight Loss/Gain _____

***Does anyone in your family have a history of*:**
Drug Abuse _____
Alcohol Abuse _____

BRIEFLY DESCRIBE ANY CURRENT MEDICAL PROBLEMS_____
_____

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?_____

DIAGNOSTIC CRITERIA

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 ___

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 see 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 c 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.**

YOU MUST COMPLETE THIS SECTION

TEMPERMENTAL TRAITS

(PLEASE CIRCLE ALL THOSE THAT APPLY)

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