

**ADOLESCENT/CHILD HEALTH HISTORY**

In order for your child's physician to best care for him/her, it is **VERY** important to have an accurate health history,

PERSON COMPLETING FORM/RELATIONSHIP: \_\_\_\_\_ DATE: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Physician(s): \_\_\_\_\_

Child in **LEGAL** custody of: \_\_\_\_\_ Home phone: \_\_\_\_\_

**FAMILY AND SOCIAL HISTORY:**

Name of Natural Father: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Name of Natural Mother: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Name of stepfather (if applicable): \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Name of stepmother (if applicable): \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Names of other adults living in home/relationship: \_\_\_\_\_

| NAME OF OTHER CHILDREN IN FAMILY | AGE | GRADE | NATURAL | STEP | ADOPTED | FOSTER |
|----------------------------------|-----|-------|---------|------|---------|--------|
|                                  |     |       |         |      |         |        |
|                                  |     |       |         |      |         |        |
|                                  |     |       |         |      |         |        |
|                                  |     |       |         |      |         |        |

**FAMILY HISTORY:**

| DISEASE                 | YES   | NO    | WHO   |
|-------------------------|-------|-------|-------|
| a. Cancer               | _____ | _____ | _____ |
| b. Heart disease        | _____ | _____ | _____ |
| c. High blood pressure  | _____ | _____ | _____ |
| d. Epilepsy             | _____ | _____ | _____ |
| e. Diabetes             | _____ | _____ | _____ |
| f. Psychiatric problems | _____ | _____ | _____ |
| g. Suicides             | _____ | _____ | _____ |
| h. Addictions           | _____ | _____ | _____ |
| l Other                 | _____ | _____ | _____ |

**HAS YOUR CHILD EVER HAD???**

|                    |       |       |
|--------------------|-------|-------|
| a. Measles         | _____ | _____ |
| b. Mumps           | _____ | _____ |
| c. Chicken pox     | _____ | _____ |
| d. Scarlet Fever   | _____ | _____ |
| e. Rheumatic fever | _____ | _____ |
| f. Seizures        | _____ | _____ |
| g. Encephalitis    | _____ | _____ |
| h. Diabetes        | _____ | _____ |

- i. Heart problems \_\_\_\_\_
- j. Whooping cough \_\_\_\_\_
- k. Lead poisoning \_\_\_\_\_
- l. Headaches \_\_\_\_\_
- m. Frequent earaches \_\_\_\_\_
- n. Frequent sore throats \_\_\_\_\_
- o. Head injury \_\_\_\_\_
- p. Frequent nose bleeds \_\_\_\_\_
- q. Fainting spells \_\_\_\_\_
- r. Dizziness \_\_\_\_\_
- s. Broken bones \_\_\_\_\_
- t. Joint problems \_\_\_\_\_
- u. Back problems \_\_\_\_\_
- v. Asthma \_\_\_\_\_
- w. Chest pain \_\_\_\_\_
- x. Shortness of breath \_\_\_\_\_
- y. Constipation \_\_\_\_\_
- z. Diarrhea \_\_\_\_\_
- aa. Problems with urination \_\_\_\_\_
- bb. Bed wetting \_\_\_\_\_
- cc. Other \_\_\_\_\_

**GENERAL**

1. Does your child currently take any medications???? *PLEASE LIST*  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
2. FOOD and/or DRUG ALLERGIES  
 \_\_\_\_\_  
 \_\_\_\_\_
3. Does your child smoke, drink alcohol or use other drugs? \_\_\_\_\_  
 If so, what? \_\_\_\_\_
4. Has your child had any surgery or serious illnesses? \_\_\_\_\_  
 \_\_\_\_\_
5. Has your child had all his/her vaccinations? Yes  NO

**PERINATAL HISTORY**

1. How was your health during pregnancy? Good Fair  Poor  (DK = don't know)
2. How old were you when your child was born? \_\_\_\_\_

Do you recall using any of the following substances or medications during pregnancy??  
 (Please circle response)

- |  |  |  |  |
|--|--|--|--|
| 3. <b>Beer or Wine</b>                 |  | 4. <b>Hard Liquor</b>                  |  |
| <input type="checkbox"/> Never         | <input type="checkbox"/> Once or twice | <input type="checkbox"/> Never         | <input type="checkbox"/> Once or twice |
| <input type="checkbox"/> 3 - 9 times   | <input type="checkbox"/> 10 - 19 times | <input type="checkbox"/> 3 - 9 times   | <input type="checkbox"/> 10 - 19 times |
| <input type="checkbox"/> 20 - 39 times | <input type="checkbox"/> 40 + times    | <input type="checkbox"/> 20 - 39 times | <input type="checkbox"/> 40 + times    |

5. **Coffee or other Caffeine**  
(Coke, etc.) Taken together  
how many times

- Never
- 3 - 9 times
- 20 - 39 times
- Once or twice
- 10 - 19 times
- 40 + times

6. **Cigarettes**

- Never
- 3 - 9 times
- 20 - 39 times
- Once or twice
- 10 - 19 times
- 40 + times

7. Did you ingest any of the following substances?

- Valium ( Librium, Xanax)
- Anti-seizure medications (i.e. Dilantin)
- Antibiotics (for viral infections)
- Illegal drugs (If so, what?) \_\_\_\_\_
- Other (please specify) \_\_\_\_\_
- Tranquilizers
- Treatment for diabetes
- Sleeping pills

**PERINATAL HISTORY**

- 8. Did you have toxemia or eclampsia? Yes  NO  Don't Know
- 9. Was there Rh factor incompatibility? Yes  NO  Don't Know
- 10. Was (s)he born on time? Yes  NO  At \_\_\_\_\_ months of pregnancy Don't Know
- 11. What was the duration of labor? \_\_\_\_\_ hours Don't Know
- 12. Were you given any drug to ease the pain during labor? Yes  NO   
name: \_\_\_\_\_
- 13. Were there indications of fetal distress during labor or birth? Yes  NO
- 14. Was delivery: Normal? Yes  NO   
Breech? Yes  NO   
Caesarian? Yes  NO   
Forceps? Yes  NO   
Induced? Yes  NO
- 15. What was the CHILD'S birth weight? \_\_\_\_\_ pounds \_\_\_\_\_ oz DK
- 16. Were there any health complications following birth? Yes  NO   
If yes, specify \_\_\_\_\_

**POSTNATAL and INFANCY**

- 17. Were there early infancy feeding problems? Yes  NO
- 18. Was the child colicky? Yes  NO
- 19. Were there early infancy sleep pattern difficulties? Yes  NO
- 20. Were there problems with the infant's responsiveness (Alertness)?? Yes  NO
- 21. Did the child experience any health problems during infancy? Yes  NO
- 22. Did the child have any congenital problems or birth defects? Yes  NO
- 23. Did the child cry a lot? Yes  NO
- 24. Did the child follow a schedule fairly well? Yes  NO
- 25. How did the baby behave with other people?  
More sociable than avg.  Average sociability  Less sociable than avg.
- 26. When (s)he wanted something, how insistent was (s)he?  
Very insistent  Pretty insistent  Average  Not very insistent  Not at all insistent

**DEVELOPMENTAL MILESTONES**

- 27. At what age did (s)he sit up \_\_\_\_\_ months or \_\_\_\_\_ years DK \_\_\_\_\_
- 28. At what age did (s)he crawl?  6 -12 months  13 - 18 months  Over 18 months  DK
- 29. At what age did (s)he walk?  Under 1 year  1 - 2 years  2 - 3 years  DK
- 30. At what age did (s)he speak single words?  9 - 13 months  14 - 18 months  19 - 24 months  
(Other than "mama" or "dada")  25 - 36 months  37 - 48 months  DK

31. At what age did (s)he string two or more words together?  
 9 - 13 months  14 - 18 months  19 - 24 months  25 - 36 months  37 - 48 months  DK
32. At what age was (s)he toilet trained? (bladder control)  
 Under 1 year  1 - 2 years  2 - 3 years  3 - 4 years  DK
33. At what age was (s)he toilet trained? (bowel control)  
 Under 1 year  1 - 2 years  2 - 3 years  3 - 4 years  DK
34. Approximately how much time did toilet training take from onset to completion?  
 Less than 1 month  1 - 2 months  2 - 3 months  More than 3 months

**MEDICAL HISTORY**

35. How would describe his/her health? Very good  Good  Fair  Poor  Very poor
36. How is his/her hearing? Very good  Good  Fair  Poor  Very poor
37. How is his/her vision? Very good  Good  Fair  Poor  Very poor
38. How is his/her gross motor coordination? Very good  Good  Fair  Poor  Very poor
39. How is his/her fine motor coordination? Very good  Good  Fair  Poor  Very poor
40. How is his/her speech articulation? Very good  Good  Fair  Poor  Very poor
41. Has the child had any accidents resulting in the following?  
 Broken bones Yes  NO  Severe lacerations Yes  NO   
 Head injury Yes  NO  Severe bruises Yes  NO   
 Stomach pumped Yes  NO  Eye injury Yes  NO   
 Lost teeth Yes  NO  Sutures Yes  NO   
 Other (specify) Yes  NO
42. How many accidents? \_\_\_\_\_
43. Has (s)he ever had surgery? Yes  NO   
**for what?** \_\_\_\_\_
44. Is there any suspicion of alcohol or drug use? Yes  NO
45. Is there any history of physical/sexual abuse? Yes  NO
46. Does the child have any sleep problems? None   
 Difficulty falling asleep  Sleep continuity disturbances  Early morning awakening
47. Is the child a restless sleeper? Yes  NO
48. Does the child have **night** bladder control problems? Yes  NO   
 If YES, how often \_\_\_\_\_  
 If yes, was (s)he ever incontinent during the day? Yes  NO   
 If YES, how often \_\_\_\_\_
49. Does the child have **night** bowel control problems? Yes  NO   
 If YES, how often \_\_\_\_\_  
 If yes, was (s)he ever incontinent during the day? Yes  NO   
 If YES, how often \_\_\_\_\_
50. Does the child have any appetite control problems? Overeats  Average  Under eats

**TREATMENT HISTORY**

51. Has the child ever been prescribed any of the following?

| Medication | YES | NO | HOW LONG USED |
|------------|-----|----|---------------|
| Ritalin    |     |    |               |
| Metadate   |     |    |               |
| Concerta   |     |    |               |
| Strattera  |     |    |               |
| Adderall   |     |    |               |
| Lithium    |     |    |               |
| Tegretol   |     |    |               |
| Depakote   |     |    |               |
| Other:     |     |    |               |
| Other:     |     |    |               |
| Other:     |     |    |               |

52. Has the child ever had any of the following forms of psychological treatments?

|                           |       |                          |       |
|---------------------------|-------|--------------------------|-------|
| INDIVIDUAL PSYCHOTHERAPY  | _____ | GROUP PSYCHOTHERAPY      | _____ |
| duration of therapy       | _____ | duration of therapy      | _____ |
| FAMILY THERAPY with CHILD | _____ | INPATIENT EVAL/TREATMENT | _____ |
| duration of therapy       | _____ | duration of therapy      | _____ |
| RESIDENTIAL TREATMENT     | _____ | <b>WHERE?</b> _____      | _____ |
| duration of therapy       | _____ | _____                    | _____ |

**WHO provided these?** \_\_\_\_\_

**SCHOOL HISTORY**

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

Preschool:

Kindergarten:

Grades 1 thru 3:

Grades 4 thru 6:

Grades 7 thru 12:

53. Has the child ever been in any type of special educational programs, and if so, how long?

|                             |       |                                     |       |
|-----------------------------|-------|-------------------------------------|-------|
| LEARNING DISABILITIES CLASS | _____ | BEHAVIORAL/EMOTIONAL DISORDER CLASS | _____ |
| duration of placement       | _____ | duration of placement               | _____ |
| RESOURCE ROOM               | _____ | SPEECH & LANGUAGE THERAPY           | _____ |
| duration of placement       | _____ | duration of placement               | _____ |
| OTHER (please specify)      | _____ | IQ TESTING                          | _____ |
| duration of placement       | _____ | The results were _____              | _____ |

OTHER information: \_\_\_\_\_

54. Has the child ever been:

|                       |       |                      |       |
|-----------------------|-------|----------------------|-------|
| number of suspensions | _____ | number of expulsions | _____ |
| <b>WHY?</b> _____     | _____ | <b>WHY?</b> _____    | _____ |
| RETAINED IN A GRADE   | _____ |                      |       |
| <b>WHY?</b> _____     | _____ |                      |       |

55. Have any additional instructional modifications been attempted in school? **Yes**  **NO**

**WHAT:** \_\_\_\_\_

**SOCIAL HISTORY**

56. How does the child get along with his/her brothers/sisters?

Doesn't have any     Better than average     Average     Worse than average

57. How easily does the child make friends?

Easier than average     Average     Worse than average     DK

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

Less than 6 months     6 months to 1 year     More than 1 year

59. What strategies have been implemented to address these problems? (check which have been successful)

|                       |       |                       |       |
|-----------------------|-------|-----------------------|-------|
| Verbal reprimands     | _____ | Rewards               | _____ |
| Time out (isolation)  | _____ | Physical punishments  | _____ |
| Removal of privileges | _____ | Acquiescence to child | _____ |
| Avoidance of child    | _____ | Other (specify) _____ | _____ |

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

Hardly ever     Sometimes     Half of the time     Most of the time     Always

61. On the average, what percentage of the time does your child eventually comply with commands?  
 Hardly ever  Sometimes  Half of the time  Most of the time  Always
62. To what extent are you and your spouse consistent with respect to disciplinary strategies?  
 Hardly ever  Sometimes  Half of the time  Most of the time  Always
63. Have any of the following stress events occurred within the past 12 months?
- |                            |       |                            |       |
|----------------------------|-------|----------------------------|-------|
| Parents divorced/separated | _____ | Family accident or illness | _____ |
| Death in family            | _____ | Parent changed job         | _____ |
| Changed school             | _____ | Family moved               | _____ |
| Family financial problems  | _____ | Other (please specify)     | _____ |

**DIAGNOSTIC CRITERIA**

64. Which of the following are considered to be a significant problem at to present time
- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Unrealistic worry about future events                      | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Unrealistic concern about appropriateness of past behavior | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Unrealistic concern about competence                       | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Somatic complaints   | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Marked self-consciousness                                  | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Excessive need for reassurance                             | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Marked inability to relax                                  | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |

65. When did the above problems begin? (Specify age) \_\_\_\_\_

66. Which of the following are considered to be a significant problem at the present time?
- |   |                              |                             |                                     |                              |                             |
|---|------------------------------|-----------------------------|-------------------------------------|------------------------------|-----------------------------|
| Fidget  | Yes <input type="checkbox"/> | NO <input type="checkbox"/> | Difficulty remaining seated         | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Easily distracted   | Yes <input type="checkbox"/> | NO <input type="checkbox"/> | Often interrupts/intrudes on others | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Often loses things  | Yes <input type="checkbox"/> | NO <input type="checkbox"/> | Difficulty following instructions   | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Often does not listen   | Yes <input type="checkbox"/> | NO <input type="checkbox"/> | Difficulty sustaining attention     | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Often talks excessively   | Yes <input type="checkbox"/> | NO <input type="checkbox"/> | Difficulty playing quietly          | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Difficulty awaiting turn  | Yes <input type="checkbox"/> | NO <input type="checkbox"/> | Shifts from one activity to another | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Often blurts out answers to questions before they have been completed | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |                                     | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Often engages in physically dangerous activities                      | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |                                     | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |

67. When did the above problems begin? (Specify age): \_\_\_\_\_

68. Which of the following are considered to be a significant problem at the present time?
- |   |                              |                             |                                   |                              |                             |
|---|------------------------------|-----------------------------|-----------------------------------|------------------------------|-----------------------------|
| Lies often                                  | Yes <input type="checkbox"/> | NO <input type="checkbox"/> | Stolen without confrontation      | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Deliberate fire setting                     | Yes <input type="checkbox"/> | NO <input type="checkbox"/> | Breaking and entering             | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Often truant                                | Yes <input type="checkbox"/> | NO <input type="checkbox"/> | Destroyed others property         | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Cruel to animals                            | Yes <input type="checkbox"/> | NO <input type="checkbox"/> | Often initiates physical fighting | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Stolen with confrontation                   | Yes <input type="checkbox"/> | NO <input type="checkbox"/> | Used a weapon in a fight          | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Physically cruel to people                  | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |                                   |                              |                             |
| Run away from home overnight at least twice |                              |                             | Yes <input type="checkbox"/>      | NO <input type="checkbox"/>  |                             |
| Forced someone else into sexual activity    |                              |                             | Yes <input type="checkbox"/>      | NO <input type="checkbox"/>  |                             |

69. When did the above problems begin? (Specify age): \_\_\_\_\_

70. Which of the following are considered to be a significant problem at the present time?
- |  |                              |                             |  |                              |                             |
|--|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| Often loses temper                                     | Yes <input type="checkbox"/> | NO <input type="checkbox"/> | Often blames others for own mistakes     | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Often angry or resentful                               | Yes <input type="checkbox"/> | NO <input type="checkbox"/> | Often swears or uses obscene language    | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Often argues with adults                               | Yes <input type="checkbox"/> | NO <input type="checkbox"/> | Often touchy or easily annoyed by others | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Often actively defies/refuses adult requests or rules  |                              |                             | Yes <input type="checkbox"/>             | NO <input type="checkbox"/>  |                             |
| Often deliberately does things that annoy other people |                              |                             | Yes <input type="checkbox"/>             | NO <input type="checkbox"/>  |                             |
| Often spiteful or vindictive                           |                              |                             | Yes <input type="checkbox"/>             | NO <input type="checkbox"/>  |                             |

71. When did the above problems begin? (Specify age): \_\_\_\_\_

72. Which of the following are considered to be a significant problem at the present time?
- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Unrealistic/persistent worry about harm to attachment figures                                       | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Persistent school refusal   | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Persistent refusal to sleep alone   | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Persistent avoidance of being alone   | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Repeated nightmares re: separation  | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Somatic complaints  | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Excessive distress in anticipation of separation from attachment figure                             | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Excessive distress when separated from home or attachment figure                                    | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Unrealistic/persistent worry that a calamitous event will separate the child from attachment figure | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
73. When did the above problems begin? (Specify age): \_\_\_\_\_
74. Which of the following are considered to be a significant problem at the present time?
- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Depressed/irritable mood most of the day nearly every day                         | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Diminished pleasures in activities  | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Decrease or increase in appetite assoc. with possible failure to make weight gain | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Insomnia (difficulty sleeping) or hypersomnia (oversleeping) nearly every day     | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Psychomotor agitation or retardation (slowing)                                    | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Fatigue or loss of energy   | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Feelings of worthlessness or excessive inappropriate guilt                        | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Diminished ability to concentrate   | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Suicidal ideation or attempt  | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
75. When did the above problems begin? (Specify age): \_\_\_\_\_
76. Which of the following are considered to be a significant problem at the present time?
- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Depressed/irritable mood most of the day nearly every day          | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Poor appetite or overeating  | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Insomnia or hypersomnia  | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Low energy or fatigue  | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Low self esteem  | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Poor concentration or difficulty making decisions                  | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Feelings of hopelessness   | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Never without symptoms for more than 2 months over a 1 year period | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
77. When did the above problems begin? (Specify age): \_\_\_\_\_

### OTHER CONCERNS

78. Has the child exhibited any of the symptoms below?
- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Stereotyped mannerisms (repeated behaviors)                  | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Odd unusual postures   | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Excessive reaction to noise or fails to react to loud noises | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Overreacts to touch  | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Compulsive rituals (doing something over and over)           | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Motor tics (involuntary muscle movements)                    | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Vocal tics (involuntary noise making)                        | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
79. Has the child exhibited any symptoms of thinking problems, including any of the following?
- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Isn't able to follow a discussion or conversation              | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Has strange ideas, sees or hears people that aren't there      | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Often mumbles or talks to himself                              | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Disoriented, confused, staring or "spacy"                      | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Complains of people talking about him/her or following him/her | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
80. Has the child exhibited any symptoms of emotional disturbance, including any of the following?
- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Excessive happiness or sadness without a change of environment | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Explosive temper with minimal reason or over little things     | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |
| Excessive clinging, attachment, or dependence of adults        | Yes <input type="checkbox"/> | NO <input type="checkbox"/> |

Unusual fears of: \_\_\_\_\_ Yes  NO   
 Strange aversions to: \_\_\_\_\_ Yes  NO   
 Panic attacks Yes  NO   
 Very quiet, sad, almost blank type of emotional availability Yes  NO   
 Situationally inappropriate emotions Yes  NO

81. Has the child exhibited any symptoms of social conduct disturbance, including any of the following?  
 Little or no interest in peers Yes  NO   
 Significantly indiscreet remarks or inappropriate social comments? Yes  NO   
 Starts or stops interactions with others inappropriately Yes  NO   
 Qualitatively abnormal social behavior misuses social cues or expressions Yes  NO   
 Excessive reaction to changes of routine Yes  NO   
 Abnormalities of speech and what? \_\_\_\_\_ Yes  NO   
 Self-mutilations (cutting/burning on self, pulling hair out, etc.) Yes  NO

82. How long have you and the child's father (mother) been married? (Please note whether the child is the product of the 1st, 2nd etc. marriage.)  
 Never were married  Separated  Divorced  Widowed  Married for \_\_\_\_\_ years

83. How stable is your current marriage?  
**Stable** \_\_\_\_\_ **Unstable** \_\_\_\_\_ **How long have you been married?** \_\_\_\_\_

84. If living together, how long? \_\_\_\_\_  
**Any particular marriage stressors?**

## PATERNAL RELATIVES (Father's side)

| T CHECK ALL YES BOXES  | FATHER | GRAND FATHER | GRAND MOTHER | UNCLE | AUNT | OTHER | OTHER |
|--|--------|--------------|--------------|-------|------|-------|-------|
| Aggressiveness, defiance& oppositional behavior as a child   |        |              |              |       |      |       |       |
| Problems with attention, activity impulse control as a child |        |              |              |       |      |       |       |
| Learning disabilities  |        |              |              |       |      |       |       |
| Failed to graduate from high school                          |        |              |              |       |      |       |       |
| Mental retardation   |        |              |              |       |      |       |       |
| Bipolar disorder for manic depression                        |        |              |              |       |      |       |       |
| Psychosis or schizophrenia                                   |        |              |              |       |      |       |       |
| Depression for greater than 2 weeks                          |        |              |              |       |      |       |       |
| Anxiety disorder that impaired adjustment                    |        |              |              |       |      |       |       |
| Tics or Tourette's   |        |              |              |       |      |       |       |
| Alcohol abuse  |        |              |              |       |      |       |       |
| Substance abuse  |        |              |              |       |      |       |       |
| Antisocial behavior (assaults, thefts, time in jail, etc.)   |        |              |              |       |      |       |       |
| Arrests  |        |              |              |       |      |       |       |
| Physical Abuse <b>V=victim P= perpetrator</b>                |        |              |              |       |      |       |       |
| Sexual Abuse <b>V=victim P= perpetrator</b>                  |        |              |              |       |      |       |       |
| Suicide attempts   |        |              |              |       |      |       |       |
| Suicide Completions  |        |              |              |       |      |       |       |
| Psychiatric Hospital Treatment                               |        |              |              |       |      |       |       |
| Alcohol / Drug Rehab Treatment                               |        |              |              |       |      |       |       |

## MATERNAL RELATIVES (Mother's side)

| T CHECK ALL YES BOXES  | FATHER | GRAND FATHER | GRAND MOTHER | UNCLE | AUNT | OTHER | OTHER |
|--|--------|--------------|--------------|-------|------|-------|-------|
| Aggressiveness, defiance& oppositional behavior as a child   |        |              |              |       |      |       |       |
| Problems with attention, activity impulse control as a child |        |              |              |       |      |       |       |
| Learning disabilities  |        |              |              |       |      |       |       |
| Failed to graduate from high school                          |        |              |              |       |      |       |       |
| Mental retardation   |        |              |              |       |      |       |       |
| Bipolar disorder for manic depression                        |        |              |              |       |      |       |       |
| Psychosis or schizophrenia                                   |        |              |              |       |      |       |       |
| Depression for greater than 2 weeks                          |        |              |              |       |      |       |       |
| Anxiety disorder that impaired adjustment                    |        |              |              |       |      |       |       |
| Tics or Tourette's   |        |              |              |       |      |       |       |
| Alcohol abuse  |        |              |              |       |      |       |       |
| Substance abuse  |        |              |              |       |      |       |       |
| Antisocial behavior (assaults, thefts, time in jail, etc.)   |        |              |              |       |      |       |       |
| Arrests  |        |              |              |       |      |       |       |
| Physical Abuse <b>V=victim P= perpetrator</b>                |        |              |              |       |      |       |       |
| Sexual Abuse <b>V=victim P= perpetrator</b>                  |        |              |              |       |      |       |       |
| Suicide attempts   |        |              |              |       |      |       |       |
| Suicide Completions  |        |              |              |       |      |       |       |
| Psychiatric Hospital Treatment                               |        |              |              |       |      |       |       |
| Alcohol / Drug Rehab Treatment                               |        |              |              |       |      |       |       |

