Emotional & Behavioral Patient Questionnaire

In order to best assist you and your child, it is important that the patient or the patient's legal guardian complete the following questionnaire prior to being seen. This information will help us better understand your child and how we can help. Do the best you can. However, if you do not know how to answer a question or choose not to answer, you may leave it blank. **CHILDREN UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY A LEGAL GUARDIAN.**

Child's Name:_____ Age:_____ Date of Birth:____/____/_____

Who is completing this form?:_____ Relationship to patient:_____

Child's Grade:_____ Name of Child's School:_____

Has there ever been DHR involvement with this child? □ Yes □ No If yes, explain:_____

_____

Who is/are the legal guardian(s) of this child?

Name:	Name:
□ Adoptive □ Biological □ Step	□ Adoptive □ Biological □ Step
□ Currently married or living with partner □ Divorced □ Separated □ Single □ Widowed	□ Currently married or living with partner □ Divorced □ Separated □ Single □ Widowed
Age:	Age:
Occupation:	Occupation:

Please list all the people currently living in the home with the child. Indicate if living full or part-time in the home:

Name	**Age**	**Relationship**	**Full or Part Time**
			Full / Part
			Full / Part
			Full / Part
			Full / Part
			Full / Part
			Full / Part
			Full / Part

List other people the child visits with (divorced parent, grandparent, etc.) that do not live 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:

□ Anxiety, nervousness, worry, or fears	□ Hyperactivity/impulse control	□ Social/friendship concerns
□ Lying	□ Destruction of property	□ Negative comments about self
□ Panic attacks	□ Inattention, disorganization	□ Bullying
□ Animal cruelty	□ Stealing	□ Repeats certain acts over and over
□ Thoughts of suicide	□ Avoids certain things or places	□ Daydreaming
□ Misinterprets ideas	□ Uncomfortable in social situations	□ Frequent temper tantrums
□ Fire setting	□ Nail biting	□ Frequent crying
□ Irritability	□ Supiciousness	□ Shy or timid
□ Extreme mood swings	□ Social withdrawal	□ Wetting or soiling
□ Poor eye contact	□ Self harm	□ Suicide attempt
□ Running away from home or school	□ Eating/weight concerns	□ School attendance/refusal
□ Oppositional/defiant behavior	□ Forgetful, memory problems	□ Alcohol/drug issues
□ Depression, moodiness	□ Academic struggles	□ Sexual behavior concerns
□ Aggression	□ Learning difficulties	□ Sleep problems/nightmares
□ Breaking rules or laws, legal issues	□ Fixations/narrow interests	□ Headaches, stomach aches, or aches/pains
□ Hallucinations (seeing or hearing things others cannot)	□ Sensory concerns (over/under reactivity to pain, lights, touch, sound, texture, etc.)	
□ Inappropriate social media engagement (explain):	□Internet content preferences (such as focus on scary/violent content, pornography exposure, etc. Explain):	
□ Collects things (specify):	□ Aggression to others (specify):	□ Unusual behavior (explain):
□ 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 list below:_____

_____

Impact of Problems:

How have these problems impacted your child and family?_____

_____

_____

School behavior, grades, and peer relationships?_____

_____

_____

Home behavior and family relationships?_____

_____

_____

Neighborhood/community relationships, legal problems?_____

_____

_____

Does the patient or family have any legal issues? □ Yes □ No

If yes, please specify charges, status, consequences, future court processes, dates if known:_____

_____

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

□ Moves	□ Parental conflict	□ Violence
□ Separation or divorce	□ Emotional abuse	□ Health issues for family members
□ Remarriage of a parent	□ Physical abuse	□ Death
□ Family member leaving the home	□ Sexual abuse	□ Legal problems
□ New family member living in the home	□ Neglect	□ Incarceration
□ Change of school	□ Poverty	□ Exposure to discrimination
□ Job changes	□ Other family changes or stressors:	

What are your goals for this evaluation and treatment? What do you hope the evaluation and treatment will accomplish? Please prioritize these goals.

1.

2.

3.

Developmental History

Any complications with pregnancy? □ Yes □ No □ Unknown
If yes, specify_____

Was mother exposed to medications during pregnancy? □ Yes □ No
If yes, what_____

Did mother use alcohol or illicit drugs during pregnancy? □ Yes □ No

Did mother use tobacco during pregnancy? □ Yes □ No

Pregnancy was for how long: □ Full Term □ Preterm □ Post Term

Delivery was: □ Vaginal □ C-Section □ Forceps/Vacuum

Birth weight: _____

Any complications postpartum such as infection, bleeding, postpartum depression (baby blues) □ Yes □ No
If yes, specify_____

□ Baby came home on time
□ Baby was transferred to the NICU for _____ days

Looking back through infancy and early childhood, how would you describe your child's activity level:
□ High □ Low □ Average

Was the baby "colicky" □ Yes □ No

Did the baby have any problems bonding? □ Yes □ No

Trouble with feeding? □ Yes □ No

Trouble with sleep? □ Yes □ No If yes, what age?_____

How would you describe his/her temperament?
□ Easy baby □ Challenging baby □ Average □ Slow to warm up □ Moderate

Looking back on the first 1-2 years of your child's life, how would you describe your child's development (sitting, walking, talking, toilet training, etc.)
□ Mostly on time or early □ Mostly late or delayed □ On time except_____

Did your child have any problems separating from you? □ Yes □ No
If yes, specify_____

Did your child attend daycare/preschool? □ Yes □ No
If yes, please list:_____

Did your child participate in any developmental intervention prior to kindergarten? □ Yes □ No
If yes, please list:_____

Emotional & Behavioral History

Has your child been seen in the **past** by a counselor or therapist for an emotional or behavioral problem?

□ Yes □ No If yes, list the details below:

Name of provider or institution	Dates of treatment	Reason for treatment	Treatment type and effectiveness

Is your child **currently** being seen by a counselor or therapist for an emotional or behavioral problem?

□ Yes □ No If yes, list the details below:

Name of provider or institution	Date began	Reason for treatment	Treatment type and effectiveness

Has your child ever been hospitalized for behavioral or emotional problems? □ Yes □ No

If yes, list the details below:

Name of institution	Dates of treatment	Reason for treatment

Has your child ever been suicidal? □ Yes □ No

If yes, was there an attempt? □ Yes □ No If yes, approximate dates:_____

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

If yes, explain:_____

Emotional & Behavioral History (cont.)

Please list all current and past **emotional or behavioral medications** that you child takes/has taken.

Medication	Current/Past	Dates of treatment	Effectiveness	Possible side effects	If discontinued, why?
	Current/Past				
	Current/Past				
	Current/Past				
	Current/Past				
	Current/Past				
	Current/Past				

Medical History

Please list all current and past chronic medications (unrelated to emotional or behavioral conditions), including vitamins and supplements, that you child takes/has taken.

Medication	Current/Past	Dates of treatment	Purpose	Possible side effects	If discontinued, why?
	Current/Past				
	Current/Past				
	Current/Past				
	Current/Past				
	Current/Past				
	Current/Past				
	Current/Past				
	Current/Past				

Other Physicians/Specialists

Name: _____ Facility: _____

Last Date Seen: _____ Conditions being treated: _____

Name: _____ Facility: _____

Last Date Seen: _____ Conditions being treated: _____

Name: _____ Facility: _____

Last Date Seen: _____ Conditions being treated: _____

Name: _____ Facility: _____

Last Date Seen: _____ Conditions being treated: _____

Name: _____ Facility: _____

Last Date Seen: _____ Conditions being treated: _____

Current or Most Recent School □ **Public** □ **Private** □ **Homeschool** **Current Grade:**_____

Has your child ever repeated a year? If yes, indicate which year and why:_____

_____

Has your child received special education designation or services? Specify type and grade level. This includes speech, tutoring, reading help, as well as learning disorder, emotional disorder, behavior disorder, advanced placement, and gifted programs: _____

_____

Does your child otherwise have an IEP separate from above? □ Yes □ No

Is there a "504 Accommodation Plan"? □ Yes □ No

Has your child ever been tested at school for learning or behavioral difficulties? □ Yes □ No

If yes, please explain and provide results if possible:_____

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.

Grade	Academic Performance	Academic Concerns	Behavioral Concerns	Additional Concerns (OT/PT, Speech/Language, Special Education, IEP)
Infancy - Preschool (0-3)				
KG - 5th Grade				
6th - 8th Grade				
9th - 12th Grade				

Has your child ever been suspended? □ Yes □ No

If yes, explain:_____

Has your child ever been sent to alternative school? □ Yes □ No

If yes, explain:_____

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	Cousins	Other (Please indicate)
Alcoholism/ Substance Abuse					P M	P M				
Anxiety					P M	P M				
Depression					P M	P M				
Suicide attempts					P M	P M				
Bipolar					P M	P M				
Schizophrenia					P M	P M				
Autism					P M	P M				
Cognitive challenges or delays					P M	P M				
Physical/ emotional abuse					P M	P M				
Sexual abuse					P M	P M				
Eating disorders					P M	P M				
Learning problems					P M	P M				
Attention problems					P M	P M				
Seizure disorder					P M	P M				
Thyroid disease					P M	P M				
Other:					P M	P M				

Child and Family Substance Use:

Do you have any concerns that your child uses substances? □ Yes □ No

If yes, explain:_____

If applicable, 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:					