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FAMILY BEHAVIORAL HEALTH
CHILD AND ADOLESCENT PSYCHIATRIC HISTORY

DEMOGRAPHIC DATA

Form filled out by:_____**Relationship to patient:**_____

Patient Name:_____**DOB:**_____**Date:**_____

Patient's Age:_____ **Sex: M ❒ F ❒** **Race**_____

Child's legal guardian:_____

Please give a brief description of the problem(s) your child is having:

_____

_____

_____

How long has the problem been going on? _____

On a scale of 1-10, how would you rate the severity of your child's problem(s) during the past month?

(Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

PAST PSYCHIATRIC HISTORY

Has your child ever had any form of mental health treatment in the past? No❒ Yes❒

If yes, please describe the type of treatment, the approximate dates and the name of the provider, agency, or hospital:

_____

_____

_____

_____

Has the patient ever made any sucicide attempts? No❒ Yes❒

If yes, please fill out the table below.

Date of Attempt	Method Used	Treatment Received (if any)

Has the patient engaged in self mutilation such as cutting, biting, scratching, or burning? No❒ Yes❒

Type of self mutilation:_____**Frequency:**_____

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Has the patient taken any psychiatric meds in the past? No❒ Yes❒ If yes, please fill out the table below.

Medication	Dates	Duration	Dosage	Benefits	Side Effects

MEDICAL HISTORY

Has the patient had a physical exam in the past year? No❒ Yes❒

Findings:_____

Current Medications - Please include medical, psychiatric, over the counter drugs, as well as herbal or nutritional supplements.

Medication	Dose	Instructions	Effectiveness	Benefits

Have there been any recent medication changes? No❒ Yes❒ Findings:_____

Medication Allergies: No❒ Yes❒

Name of drug followed by reaction:_____

Current Medical Problems:

_____

_____

Past Medical/Surgical History:

_____

_____

Medical History Questions	No	Yes	Effectiveness
Does the child have vision problems?			
Does the child have hearing problems?			

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Has the child ever had a seizure?			
Has the child ever had a head injury?			
Did the head injury result in loss of consciousness?			
Did the child receive treatment for the head injury?			

Has the patient ever had any of the following tests?

Name of Test	No	Yes	Date	Results
MRI or CAT scan of the head				
EEG (a test for seizures)				
EKG (a heart test)				

FAMILY MEDICAL HISTORY

Please check any of the following conditions that have affected an immediate or extended family member related by blood. Indicate maternal (mother) or paternal (father) side.

Condition	Family Member	Mat/Pat	Condition	Family Member	Mat/Pat
Autoimmune disorder			**Live disease**		
Blood disorders			**Migraines**		
Cancer			**Muscle disorder**		
Diabetes			**Obesity**		
Heart disease			**Seizures**		
Hepatitis			**Stroke**		
High blood pressure			**T.B.**		
Kidney disease			**Thyroid disease**		
Leukemia			**Other:**		

FAMILY PSYCHIATRIC HISTORY

Please check any of the following conditions that have affected an immediate or extended family member related by blood. Indicate maternal (mother) or paternal (father) side.

Condition	Family Member	Mat/Pat	Condition	Family Member	Mat/Pat

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Alcoholism			**Hyperactivity**		
Anxiety problems			**Learning disability**		
Arrests			**Mental retardation**		
Autism			**Mood swings**		
Attention problems			**Schizophrenia**		
Bipolar disorder			**Substance abuse**		
Depression			**Tics or tourette's**		
Dropped out of school			**violence**		
Eating disorder			**Suicide attempts**		
Hallucinations			**Other:**		

SOCIAL HISTORY

How does the child get along with:

Peers?		**Parents?**	
Teachers?		**Siblings?**	

Father's occupation:_____**Mother's occupation:**_____

Is the child adopted? No❒ Yes❒ If yes, how old was the child when he/she came to live with you?_____

Does the child know he/she is adopted? No❒ Yes❒

Are the child's parents divorced? No❒ Yes❒ If yes, what are the custody visitation arrangements?

_____

Please list all persons who currently live in the child's household:

Name	Relationship	Age

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List any immediate family members not living with the child (i.e. mother, father, or siblings).

Name	Relationship	Age

Has the child ever experienced or been exposed to any of the following?

	No	Yes	Explanation
Physical abuse			
Sexual abuse			
Emotional abuse			
Neglect			
Domestic violence			

DEVELOPMENTAL HISTORY

Mother's age when child was born:_____Father's age when child was born:_____

Child's birth weight:_____ Apgar scores (if known):_____

Type of delivery: ❒ Vaginal ❒ Induced ❒ Scheduled C-section ❒ Emergency C-section

Questions	No	Yes	Explanation
Was the pregnancy planned?			
Were there problems during the pregnancy?			
Did the mother receive regular prenatal care?			
Did the mother take medication during pregnancy?			
Did the mother drink alcohol during the pregnancy?			
Did the mother take drugs during the pregnancy?			

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Did the mother smoke during the pregnancy?			
Were there any problems during the labor?			
Were there any complications during the delivery?			
Were there any problems after the birth?			
Did the mother suffer from postpartum depression?			
Was the child premature or late?			
Did the child have a consistent caretaker?			

What was the child like as a baby?_____

Did the child experience delays or impairments in any of the following areas?

	No	Yes		No	Yes
Feeding			**Gross motor skills (running, jumping, skipping)**		
Toilet training			**Fine motor skills (writing, coloring, cutting)**		
Speech/language			**Bedwetting after toilet trained mastered**		
Walking			**Soiling after toilet training mastered**		
Other					

EDUCATIONAL HISTORY

Current school:_____**Grade:**_____

Type of classroom: ❒ mainstream ❒ special education ❒ self-contained ❒ emotionally disturbed

Does the patient have an Individual Education Plan (IEP) or 504 plan (accomodations)? ❒ No ❒ Yes

Has the child had any psychological or educational testing? ❒ No ❒ Yes

Where and when was the testing done?_____

Has the child ever repeated a grade? ❒ No ❒ Yes If yes, which one?_____

Has the child ever been diagnosed with a learning disability? ❒ No ❒ Yes_____

Has the child ever been diagnosed with: ❒Mental retardation ❒Autism ❒Aspergers

SUBSTANCE ABUSE HISTORY

Has the patient used any of the following substances? ❒ No ❒ Yes

Substance	Age of 1st Use	Date of Last Use	Amount Consumed	Frequency of Use	Route of Administration

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Alcohol					
Acid/LSD/PCP					
Crystal Meth/Speed					
Cocaine/Crack					
Ecstasy					
Heroin					
Inhalants					
Marijuana/Pot					
Methadone					
Nicotine					
Opiates/Pain Killers					
Sedatives/Downers					
Other					

LEGAL HISTORY

Has the patient ever been arrested, charged or placed on probation or parole? ❒ No ❒ Yes

If yes, what were the charges?_____

Has the child ever been held in Juvenile Detention? ❒ No ❒ Yes If yes, how many times?_____

PSYCHIATRIC SYMPTOMS

Please check any of the following symptoms your child has experienced in the past year.

Physical

❒ Problems falling asleep or staying asleep
❒ Sleeps a lot
❒ Change in appetite ____increased ____decreased
❒ Change in weight ____increased ____decreased
❒ Tiredness or fatigue
❒ Headaches
❒ Stomach pains
❒ Joint pain or swelling
❒ Agitation or restlessness
❒ Poor hygiene
❒ Soiling (lack of bowel control)
❒ Bedwetting
❒ Wetting during the day
❒ Chest pain
❒ Shortness in breath
❒ Dizziness
❒ Heart palpitations or racing heart
❒ Feeling faint
❒ Fainting spells

Cognitive

❒ Decreased concentration
❒ Easily distracted
❒ Forgetfulness
❒ Confusion or disorientation
❒ Unresponsive at times
❒ Slowed thinking

Psychological

❒ Periods of elevated mood, excessive talking, giddy or silly behavior, uncontrollable laughing
❒ Hearing voices
❒ Seeing things that aren't there
❒ Fears that someone is trying to hurt him/her
❒ Acts paranoid
❒ Becomes distressed when away from caregiver
❒ Clingy behavior
❒ Afraid to be alone
❒ Excessive worries
❒ Fears
❒ Nightmares
❒ Obsessive and distressing thoughts
❒ Compulsive behaviors or rituals (excessive hand washing, arranging, checking)
❒ Repetitive movements (eye blinking, facial/nose twitches, mouth movements)

❒ **Repetitive sounds (sniffing, snorting, grunting, growling, clearing the throat)**

Behavioral

❒ **Hyperactivity**
❒ **Impulsivity**
❒ **Oppositional/defiant behavior**
❒ **Argumentative**
❒ **Destructive**
❒ **Anger outbursts**
❒ **Rages that may last up to an hour or more**
❒ **Cruelty to others**
❒ **Crueltyto animals**
❒ **Bullies or teases others**
❒ **Firesetting**
❒ **Has runaway from home**
❒ **Physical aggression**
❒ **Lies**
❒ **Steals**
❒ **Refuses to do chores**
❒ **Demonstrates poor judgment**
❒ **Inappropriate sexual behavior**
❒ **School refusal**
❒ **Withdrawal from family/friends**

Communication

❒ **Difficulty communicating his/her thoughts or wishes to other**
❒ **Difficulty understanding verbal or written language**
❒ **Difficulty speaking words clearly**
❒ **Stutters**

Academic

❒ **Difficulty reading at grade level**
❒ **Difficulty doing math at grade level**
❒ **Difficulty writing at grade level**

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MOOD DISORDER QUESTIONNAIRE
Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and...
❒...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?
❒...you were so irritable that you shouted at people or started fights or arguments?
❒...you felt much more self-confident than usual?
❒...you got much less sleep than usual and found you didn't really miss it?
❒...you were much more talkative or spoke much faster than usual?
❒...thoughts raced through your head or you couldn't slow your mind down?
❒...you were so easily distracted by things around you that you had trouble concentrating or staying on track?
❒...you had much more energy than usual?
❒...you were much more active or did many more things than usual?
❒...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?
❒...you were much more interested in sex than usual?
❒...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?
❒...spending money got you or your family into trouble?

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?

❒No ❒Yes

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights?

❒No Problem ❒Minor Problem ❒Moderate Problem ❒Serious Problem

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BECK'S DEPRESSION INVENTORY
This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.0 I do not feel sad.
1 I feel sad
2 I am sad all the time and I can't snap out of it.
3 I am so sad and unhappy that I can't stand it.

2.
0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel the future is hopeless and that things cannot improve.

3.
0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4.
0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5.
0 I don't feel particularly guilty
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6.
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7.
0 I don't feel disappointed in myself.
1 I am disappointed in myself.

2 I am disgusted with myself.
3 I hate myself.

8.
0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9.
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10.
0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11.
0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.
0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.
0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than I used to.
3 I can't make decisions at all anymore.

14.
0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15.
0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.
0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.
0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.
0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.
0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.
0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.
0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

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INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circle zero on each question.

You can evaluate your depression according to the Table below.

Total Score	Levels of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
Over 40	Extreme depression

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ADHD CHECKLIST

Symptoms of Inattention* (Six or more of these)	**Never**	**Sometimes**	**Often**	**Very Often**
Does not give close attention to details or makes careless mistakes in schoolwork, work, or other activities				
Has trouble sustaining attention in tasks or play activities				
Does not seem to listen when spoken to directly				
Does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace				
Has trouble organizing tasks and activities				
Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as homework)				
Loses things necessary for tasks or activities (tous, school assignments, pencils, books, or tools)				
Is easily distracted by external stimuli				
Is forgetful in daily activities				
Symptoms of Hyperactivity & Impulsivity* (Six or more of these)				
Hyperactivity				
Fidgets with hands or feet or squirms in seat				
Leaves seat in classroom or in other situations in which remaining seated is expected				
Runs about or climbs when and where it is inappropriate				
Has trouble playing quietly or enjoying leisure activities quietly				
Is ‘on the go’ or acts as if ‘driven by motor’				
Talks excessively				
Impulsivity				
Blurts out answers before questions have been completed				

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Has trouble waiting his or her turn				
Interrupts or intrudes on others (such as butting into conversations)				