



DELTA FAMILY CLINIC SOUTH P.C.

CHILD PSYCHOSOCIAL QUESTIONNAIRE

*Please fill out every section of this form to the best of your ability. If a section does not pertain to you please write "N/A".
Any unfinished forms will be returned to patient/patient guardian upon staff review. Thank you!*

Child's Full Name: _____ Today's Date: _____

Nickname, if any: _____ DOB: _____ Age: _____ Sex: _____

Legal Guardian's Name: _____ Relation to patient: _____

Cell #:(_____) _____ Home #: (_____) _____

Statement of problem/reason for appointment (including any specific reasons for seeking help at this time):

Who referred you and your child to Delta Family Clinic?

(If a primary care/specialty doctor referred please provide street name/address or location.) _____

I. FAMILY HISTORY:

Mother's name: _____ Birth Date: _____

Occupation: _____ State of Health: _____

Father's name: _____ Birth Date: _____

Occupation: _____ State of Health: _____

Are both parents in the home? Yes No

Are both parents living? Yes No

If No, Mother is deceased Yes No **OR** Father is deceased Yes No

Are the parents separated or divorced? Yes No

If Yes, does the child visit/spend time with the other parent? Yes No

If Yes, how often do visits occur? _____

Age of child at death or divorce? _____

Does the child have a step-parent? Yes No

Does the child have a foster parent? Yes No

Age of child at remarriage? _____ Length of present marriage? _____

Brothers and Sisters (Please list all children: step and half-sister and/or brothers)

Name	Birth date	Age	Child Lives in the home
_____	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do the patient's siblings have any difficulties in school? Yes No

If yes, please list the specific academic difficulties the patient's siblings experience _____

Others living in home: (give age and relationship) _____

Has your child ever had any of the following evaluations?

Psychological Yes No If Yes, Where _____ When _____

Speech Yes No If Yes, Where _____ When _____

Eye/Vision Yes No If Yes, Where _____ When _____

Neurological Yes No If Yes, Where _____ When _____

Physical Yes No If Yes, Where _____ When _____

Does your child have any handicaps (visual, auditory, speech, language, muscular)? Yes No

If yes, please explain: _____

Patient Name: _____ DOB: _____

II. BIRTH AND PRENATAL HISTORY:

Is the child adopted? Yes No If yes, at what age? _____

Did the mother receive prenatal care? Yes No
If yes, which month did the mother first see a doctor? _____

During this pregnancy, did the mother have any unusual illnesses, conditions, accidents, such as German measles, false labor spotting, swelling or water retention, toxemia, RH incompatibility, diabetes, etc? If so, describe: _____

Any medications taken during pregnancy? Yes No If yes, what? _____

Hours spent in labor: _____ Was labor induced? Yes No

Length: full term, premature, post mature (number of months long) _____

Delivery: C Section, instruments used (forceps), easy, difficult, normal? _____

Did child's head or feet come first? Yes No Was the mother awake? _____

Birth weight: _____ Length: _____

After birth, was the child blue? Yes No Jaundiced (yellow)? Yes No

Bruised or scarred? Yes No Other? (explain) _____

Any sucking or swallowing problems? Yes No

Did the infant have breathing problems? Yes No If yes to either, for how long? _____

Any feeding problems? Yes No If yes, please explain: _____

III. DEVELOPMENT:

State the approximate age at which your child did these things:

Held head up _____ Sat alone _____ Crawled _____

Pulled up to standing position _____ Walked alone _____ Breast fed to Age _____

Ate solid food _____ Used a spoon/fork _____ Drank from a cup _____

Babbled _____ Used gestures meaningfully _____ Spoke single words _____

Spoke in phrases _____ Spoke in complete sentences _____

Did your child self-wean? Yes No If yes, at what age? _____

Did your child have special diet needs? Yes No If yes, explain: _____

Patient Name: _____ DOB: _____

Training Information

Bladder control: Daytime issues in the past Yes No Daytime issues currently Yes No
 Nighttime issues in the past Yes No Nighttime issues currently Yes No
 Training started _____ Training finished _____

Bowel control: Daytime issues in the past Yes No Daytime issues currently Yes No
 Nighttime issues in the past Yes No Nighttime issues currently Yes No
 Training started _____ Training finished _____

Daytime accidents to age: _____ **Night time accidents to age:** _____

How did the patient's growth/development compare with that of his/her siblings? Describe: _____

IV. HEALTH HISTORY:

Please indicate the age your child experienced these things, and whether they were mild, average, severe, and if there were any after effects.

Measles _____	High fevers _____	Chicken pox _____
Head injury _____	Mumps _____	Heart disease _____
Whooping cough _____	Rheumatic fever _____	Allergies _____
Hay fever _____	Tuberculosis _____	Asthma _____
Meningitis _____	Eczema _____	Kidney Disease _____
Pleurisy _____	Nerve Disorder _____	Muscle Disorder _____
Hives _____	Frequent Colds _____	Paralysis _____
Croup _____	Cerebral Palsy _____	Tonsillitis _____
Epilepsy _____	Influenza _____	Seizures _____
Ear Ache _____	Enlarged Glands _____	Hearing Problems _____
Tongue Tie Clip _____	Eye Problems _____	Poisoning _____
Overweight _____	Diphtheria _____	Underweight _____
Typhoid _____	Staring Spells _____	Dysentery _____
Fainting Spells _____	Suicide Attempts _____	

Patient Name: _____ **DOB:** _____

Does anyone in the family have a history of the above or any other illness of handicap? If yes, please explain:

Immunization	In process	Complete	None	Reaction (if any)
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Family (or child's) physician (if you have one) _____

Has this child ever been abused, abandoned, neglected, or exploited in any way? Yes No

If yes, please explain: _____

Please describe any serious accidents or operations the child has had: _____

Is the child currently taking any prescribed medications(s)? No Yes

If yes, please list them below:

Drug Name	Route (oral, injection, etc.)	Dose	Frequency

Please list any long-term medications that the child no longer takes:

Current state of child's health: _____

Patient Name: _____ DOB: _____

V. SUBSTANCE USE/ABUSE:

Please note the usage of any of the following substances:

	If yes, age of first use:	Method of Use: (injected, Inhaled, Ingested, Snorted)	Date/Age last used:	Amount used in last 30 days:	Amount used in the last 48 hours:
Alcohol					
Sedatives					
Cannabis					
Stimulants					
Cocaine					
Opioids					
Hallucinogens					
Other					

Examples:

Alcohol: Beer, wine, liquor, mixed drinks, coolers:

Sedatives-hypnotics-tranquilizers: Seconal, Valium, Xanax, Librium, Barbiturates, Miltown, Ativan, Dalmanc, Halcion, Restoril, Reds, Yellos, Placidyl, Klonopin, Phenergan, Phenobarbital, Tuinal, Nembital, Quaalude, or other:

Cannabis: Marijuana, Hashish, Liquid THC, or other:

Stimulants: Amphetamine, Speed, Crystal Meth (Crank), Dexedrine, Ritalin, Ice, Black Beauties, Preludin (Bam), crossroads, or other:

Cocaine: Freebase, Crack, "Speedball," Powder, or other:

Opioids: Heroin, Opium, Morphine, Methadone, Darvon, Codeine, Percodan, Demerol, Dilaudid, Cough Syrup w/ codeine, Dolophine, Tylox, Tylenol #3 or #4, Pantapone, or other:

Hallucinogens/PCP: LSD (Window pane, Acid, Microdot), Mescaline, Peyote, Psilocybin, STP, Mushrooms, PCP (Angel dust, Flakes, Greens), Ecstasy, MDMA, MDA, or other:

Other: Steroids, Glue, Paint, Nitrous Oxide (Laughing gas), Amyl or Butyl Nitrate (poppers, rush), Nonprescription sleep or diet pills, Clonidine, Elavil, Sinequan, Excedrin, NoDoz, Dexatrim, Caffedrine, Quick-Pep, Vivarin, or other:

VI. APPETITE:

Does the child have a good appetite? Yes No How many meals does the child eat each day? _____

Is there excessive snacking? Yes No Excessive sugar eaten? Yes No

VII. SLEEPING HABITS:

Usual number of hours of sleep _____ How many hours at naptime? _____ Bedtime? _____

Time child goes to bed? _____ Time child gets up in the morning? _____

Does the child seem to require a lot of sleep (more than 12 hours a day)? Yes No

Does the child seem to require little sleep (less than 8 hours a day)? Yes No

Patient Name: _____ DOB: _____

Where does the child usually sleep (crib, junior, adult bed)? _____

Does child sleep alone? Yes No If No, who does the child sleep with? _____

Does child sleep well? Yes No

Does the child have any routine at bedtime? Yes No If Yes, please explain: _____

Any sleeping problems (nightmares, sleepwalking, etc.)? _____

VIII. SOCIAL DEVELOPMENT:

How does the child get along in the home? _____

How does the child get along with the mother? _____

Father? _____ Brothers? _____

Sisters? _____ Adults? _____

Strangers? _____ Children child's own age? _____

Younger? _____ Older? _____

Pets? _____

Do you see any changes occurring? _____

Time spent watching T.V. each day? _____

Any strong attachment outside the home? _____

Does child dress themselves? Yes No How much help does child need getting dressed? _____

Does child ever put wrong arm in sleeve? Yes No Does child select clothes to wear? Yes No

Can child leave yard? Yes No Permission required? Yes No

What kind of toys and play does the child like most? _____

Does the child play alone? Yes No Does the child play with others? Yes No

What does your child like to do for fun? _____

Does child help with simple jobs, such as picking up toys? Yes No

What chores does the child help with? _____

Does child share feelings easily? Yes No Pain? Yes No Anger? Yes No

Patient Name: _____ DOB: _____

Does the child share toys? Yes No

Does the child have any fears? (describe): _____

Any previous nursery school experience? Yes No

Please check the corresponding lines if your child is described by any of the following:

- | | |
|---------------------------------|---|
| _____ very active | _____ frequent accidents, tripping, falling |
| _____ very calm, quiet | _____ loses balance easily |
| _____ restless | _____ unusual walk |
| _____ difficulty sitting still | _____ right handed |
| _____ nervous or tense | _____ left handed |
| _____ affectionate | _____ uses both hands alternately |
| _____ good natured | _____ has handedness been changed? |
| _____ easily angered | _____ grew rapidly |
| _____ cries easily | _____ grew slowly |
| _____ frequent mood changes | _____ difficulties chewing or swallowing |
| _____ rocks body back & forth | _____ long periods of little or no growth |
| _____ when sitting | _____ speech difficulties |
| _____ rocks body when standing | _____ poor eating habits |
| _____ uncontrolled facial jerks | _____ frequently ill |
| _____ clumsy, awkward | |

Please describe any of the previous items you feel are of concern: _____

Does the child experience mood cycling? Yes No If yes, explain: _____

Does the child experience mood changes without the presence of precipitants? Yes No

If yes, explain: _____

IX. DISCIPLINE:

Check off which of the following types of discipline you use most often on the child:

- | | |
|------------------------------------|------------------------------|
| _____ Talk with child | _____ Reasoning |
| _____ Physical | _____ Taking away privileges |
| _____ Persuasion | |
| _____ Other, please explain: _____ | |

Who disciplines most? _____ Agreement on discipline? Yes No

Any big change in discipline methods by you or others? Yes No

If yes, explain: _____

Do you have any problems managing or controlling your child? Yes No

If yes, explain: _____

Describe your child's reaction to discipline (does it work): _____

Patient Name: _____ DOB: _____

X. SCHOOL:

Current grade level in school (K-12)? _____ Average grades received last term: _____ Now: _____

Current goals in school: _____

How does child get along with children in school? _____

Special Education? Yes No

At what grade did Special Education begin? _____ End? _____

Why is the child in Special Education? _____

Has the child ever been held back or skipped a grade? Yes No

If yes, which grade? _____ For what reason? _____

Any problems in school behavior reported to you by teachers? Yes No

Describe the reported problem: _____

Any suspensions? Yes No If yes, why? _____

When did suspensions begin? Grade: _____

Has child ever been in trouble due to stealing? Yes No Use of drugs/alcohol? Yes No

Threatening other students? Explain: _____

XI. PREVIOUS PSYCHOLOGICAL TREATMENT:

Please list any therapists and agencies the child has been in treatment with (inpatient or outpatient) as well as the beginning and ending dates of treatment and the reason for treatment:

<i>Therapist/Agency</i>	<i>Duration of Treatment</i>	<i>Reason for Treatment</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

XII. JUVENILE HISTORY:

Has there ever been a time your child has been arrested and appeared in Juvenile Court? Yes No

If yes, explain: _____

Does your child have any history of being removed from your care and placed in Foster Care? Yes No

If yes, explain: _____

Patient Name: _____ DOB: _____

XIII. ADDITIONAL COMMENTS OR CONCERNS:

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR CHILD:

Please specify why the child is being referred. State any questions you would like answered: _____

Any specific background information or behavior that led to the referral? _____

When did the problem start? _____

Was there anything that happened at the time the problem began that might be related to the difficulty? _____

Please list any friends or family members who you think will be supportive of the patient's treatment.
Name of person(s) and relationship to patient:

What else would you like to tell us or think we should know about this patient and their current difficulties?

Parent and/or Legal Guardian Name (Printed)

Date

Parent and/or Legal Guardian Signature

Date

Reviewing Clinician Signature

Date

Patient Name: _____ DOB: _____