DELTA FAMILY CLINIC SOUTH P.C.

Delta Family Clinic
Treatment you can trust!

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? □ Yes □ No 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: Note if step and half-sister and/or brothers)

Name	(Circle one)	Birth date	Age	Child Lives in the home
_____	(Step/Half/Full)	_____/_____/_____	_____	**□ Yes □ No**
_____	(Step/Half/Full)	_____/_____/_____	_____	**□ Yes □ No**
_____	(Step/Half/Full)	_____/_____/_____	_____	**□ Yes □ No**
_____	(Step/Half/Full)	_____/_____/_____	_____	**□ Yes □ No**
_____	(Step/Half/Full)	_____/_____/_____	_____	**□ Yes □ No**
_____	(Step/Half/Full)	_____/_____/_____	_____	**□ Yes □ 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? _____

Was there a history of substance use or abuse during, prior to, or post-delivery (specify)? _____

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 (Circle one)? □ 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: _____

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_____	Other _____

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)
_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	_____
_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	_____
_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	_____
_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	_____

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

Date of child's last physical examination: _____

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, Pantapon, or other:
Hallucinogens/PCP: LSD (Window pane, Acid, Microdot), Mescalline, 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? _____ T**ime 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 (explain)?_____

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

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

_____

Does the child experience mood changes without obvious cause? □ Yes □ No If yes, explain: _____

_____

Does the child experience mood cycling (i.e. mood swings that quickly go from low to high and back again, and occur over periods of a few days and sometimes even a few hours)? □ 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
_____ Physical
_____ Persuasion
_____ Other, please explain: _____
_____ Reasoning
_____ Taking away privileges

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): _____

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 (circle which)? □ 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:

Therapist/Agency ***Duration of Treatment*** ***Reason for Treatment***

_____

_____

_____

_____

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:** _____