Delta Family Clinic 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!

Demographics:

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

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

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

Primary Phone #:(_____)_____ Secondary Phone #: (_____)_____

Current Address: _____

Family History:

Mother's name: _____ Birth Date: _____

Occupation: _____ Current State of Health: _____

Father's name: _____ Birth Date: _____

Occupation: _____ Current State of Health: _____

Are both parents in the home? □ Yes □ No

If no, please explain: _____

Are both parents living? □ Yes □ No

If no, please explain (include age of child at death): _____

Are the parents separated/divorced? □ Yes □ No

If yes, age of child at separation/divorce? _____

Does the child have a stepparent? □ Yes □ No

If yes, age of child at remarriage? _____ Length of present marriage? _____

Please fill out the following information to reflect any patient siblings:

Sibling Gender (Male/Female)	(Circle one)	Age	Child Lives in the home
□ Male □ Female	(Step/Half/Full)	_____	□ Yes □ No
□ Male □ Female	(Step/Half/Full)	_____	□ Yes □ No
□ Male □ Female	(Step/Half/Full)	_____	□ Yes □ No
□ Male □ Female	(Step/Half/Full)	_____	□ Yes □ No
□ Male □ Female	(Step/Half/Full)	_____	□ Yes □ No

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

Birth and Prenatal History:

Delta Family Clinic understands that birth, prenatal and developmental histories are often hard to recall, especially in cases in which no abnormalities occurred and/or an extended period has passed since the birth of the child. Please fill out to the best of your ability and mark unknown questions "N/A".

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

Was there a history of substance use or abuse during, prior to, or post-delivery? If yes, 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 yes, please describe:

_____

Did the mother take any medications during pregnancy? □ Yes □ No

If yes, please list medications: _____

How many hours were spent in labor? _____

Was labor induced? □ Yes □ No

Was the pregnancy full term, premature, or post mature? _____

Was delivery vaginal or via C-Section? _____

Did child's head or feet come first? □ Head □ Feet

Was the mother awake? _____

Birth weight: _____ Length: _____

After birth was the child blue? □ Yes □ No Jaundiced (yellow)? □ Yes □ No Bruised or scarred? □ Yes □ No

Did the infant experience any sucking or swallowing problems? □ Yes □ No

Did the infant have breathing problems? □ Yes □ No Did the infant experience any feeding problems? □ Yes □ No

Development:

State the approximate age at which your child hit the following milestones. If unknown, please mark "N/A":

Milestone	**Age Accomplished**
Held head up	
Sat alone	
Crawled	
Pulled up to standing position	
Walked alone	
Discontinued breast/bottle feeding	
Used a spoon/fork	
Drank from a cup	
Ate solid food	
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, please explain: _____

How did the patient's growth/development compare with that of his/her siblings? (Circle one) Good Fair Poor

Do you see any changes occurring in your child's social development? If yes, please explain: _____

_____

Did the child experience any potty-training issues? □ Yes □ No

If yes, please explain: _____

Did the child experience any bladder/bowel control issues in the past? □ Yes □ No If yes, at what age did issues resolve? _____

Does the child experience any bladder/bowel control issues currently? □ Yes □ No

Please indicate if you child experienced any of the following:

- □ Measles
- □ Head Injury
- □ Whooping cough
- □ Hay fever
- □ Meningitis
- □ Pleurisy
- □ Hives
- □ Croup
- □ Epilepsy
- □ Earache
- □ Tongue tie clip
- □ Overweight
- □ Typhoid
- □ Fainting Spells
- □ High fevers
- □ Mumps
- □ Rheumatic fever
- □ Tuberculosis
- □ Eczema
- □ Nerve Disorder
- □ Frequent colds
- □ Cerebral palsy
- □ Influenza
- □ Enlarged glands
- □ Eye problems
- □ Diphtheria
- □ Staring spells
- □ Suicide attempts
- □ Chicken pox
- □ Heart disease
- □ Allergies
- □ Asthma
- □ Kidney disease
- □ Muscle disorder
- □ Paralysis
- □ Tonsilitis
- □ Seizures
- □ Hearing problems
- □ Poisoning
- □ Underweight
- □ Dysentery
- □ Other: _____

Does your child have any handicaps (visual, auditory, speech, language, muscular)? □ 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: _____

Has this child ever experienced abuse, abandonment, neglect, trauma, or exploitation in any way? □ Yes □ No

If yes, please explain: _____

Patient name: _____ DOB: _____

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

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

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
- □ Uncontrolled facial jerks
- □ Clumsy, awkward
- □ Has handedness been changed?
- □ Frequently ill
- □ Easily angered
- □ Grew rapidly
- □ Cries easily
- □ Grew slowly
- □ Frequent mood changes
- □ Difficulties chewing or swallowing
- □ Rocks body back & forth when sitting
- □ Long periods of little or no growth
- □ Speech difficulties
- □ Rocks body when standing
- □ Poor eating habits

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

Does the child experience mood changes without obvious cause? □ Yes □ No

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

Please check off any of the following symptoms/areas of concern your child is experiencing:

- □ Grief/Loss
- □ Obsessive Compulsive Behavior
- □ Post-Traumatic Stress Disorder
- □ Conduct Issues (Child)
- □ Mood Instability
- □ Prior or Current Physical/Verbal/Sexual Abuse
- □ Prior or Current Suicidal/Homicidal Ideation
- □ Depression
- □ Substance Abuse
- □ Academic Issues/Learning Disability
- □ Decision Making
- □ Pain
- □ Stress
- □ Education
- □ Drug abuse
- □ Friends
- □ Stomach/Bowel Trouble
- □ Legal Matters
- □ Inability to relax
- □ Self-control
- □ Shyness
- □ Marital Issues
- □ Headaches
- □ Health Problems
- □ Alcohol Use
- □ Ambition
- □ Concentration
- □ Nightmares
- □ Divorce/Separation
- □ Memory issues
- □ Temper tantrums
- □ Confusion/Indecision
- □ Loneliness
- □ Appetite/Eating
- □ Sleep issues
- □ Anxiety/fearfulness
- □ Energy levels
- □ Depression/sadness
- □ Guilt/shame
- □ Thoughts of self-harm
- □ Feelings of inadequacy

Education:

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

Current goals in school: _____

Patient name: _____ DOB: _____

How does child get along with children in school? _____

Special Education? □ Yes □ No If yes, 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: _____

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*

_____

_____

Juvenile History:

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

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

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? _____

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***

Patient name: _____ DOB: _____

Office Staff Only:

_____ _____

Reviewing Clinician Signature ***Date***