

Children's Resource Group
9106 N. Meridian St., Suite 100
Indianapolis, IN 46260
TEL: (317) 575-9111 FAX: (317) 571-4470

Child/Adolescent Questionnaire

Child's Name:	Child's Nickname:	Birth Date:
Person Completing Questionnaire:	Relationship to Patient:	Date:

HOW DID YOU HEAR ABOUT CRG:

- Family Dr. (Dr.'s name: _____)
- Therapist (therapist's name: _____)
- School (school name: _____)
- Family member
- Friend / Coworker
- CRG Website
- Other (_____)

FAMILY INFORMATION

Mother's Name: _____

Father's Name: _____

Step-Mother's Name (if applicable): _____

Step-Father's Name (if applicable): _____

Please list the Name and Relationship of additional family members that will be involved in your child's care:

Parents are: Date

Married ___ _____

Separated ___ _____

Divorced* ___ _____

Unmarried ___ _____

Widowed ___ _____

*If parents are divorced, please describe current custody and visitation arrangements: _____

Is your child a foster child? ___ Yes ___ No Length of time in your home _____

Is child adopted? ___ Yes ___ No Age at adoption _____

If a foster child or adopted, has this been discussed with your child? ___ Yes ___ No

Who has legal guardianship of the child? _____

Who provides primary care to the child when parent(s) are at work? _____

What is the child's ethnic background/race? _____

What is the child's religious affiliation? _____

Please list all persons presently living in your home:

Name	Sex	Age	Relation to Child	Present or Highest Grade Completed	Occupation

Immediate family members not living in the child's home:

Name	Sex	Age	Relation to Child	Present or Highest Grade Completed	Occupation

During the past 12 months, has your family experienced any of the following difficulties?

	Yes	No	Comments
Death of a family member			
Serious illness			
Marital problems			
Unemployment/Financial Trouble			
Abuse (sexual, verbal, physical)			
Neglect/Abandonment			
Other significant events/losses/changes			

PURPOSE OF EVALUATION

What are your questions or concerns regarding your child?

When did you first become concerned about your child?

PAST MEDICAL ILLNESSES

	Yes	No	Comments
Has your child ever been hospitalized? If yes, please describe, including child's age.			
Has your child ever had any serious accidents requiring medical care? If yes, please describe, including your child's age. (Include broken bones.)			
Has your child had or currently have any serious or chronic illnesses? Please describe.			
Has your child ever had a seizure or convulsion? If yes, please describe, including child's age.			
Has your child ever had tics? (Facial movements, eye-blinking, etc.)			
Does your child have any known allergies? Please describe.			
Do you feel your child has trouble hearing? If yes, please explain.			
Do you feel your child has trouble seeing? If yes, please explain.			
Are you concerned about your child's eating habits? If yes, please describe.			
Are you concerned about your child's sleep habits? If yes, please describe; include trouble falling asleep, not being able to sleep in own room, nightmares, awakenings, snoring, and trouble waking up.			
Does your child have headaches more than once a week?			
Does your child have stomachaches more than once a week?			
Is your child presently taking any medication? If yes, please list the medications, dosages, by whom it was prescribed and why.			

CHILD'S BEHAVIOR

Please indicate any of the following behaviors that you observe with your child; please describe any areas of concern:

Vanderbilt Parent Rating Scale

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty staying focused on what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and vindictive (wants to get even)	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3

Symptoms	Never	Occasionally	Often	Very Often
29. Lies to get out of trouble or to avoid obligations (i.e., "cons" others)	0	1	2	3
30. Skips school without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him/her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

EDUCATIONAL HISTORY

Please list your child's schools:

	<u>Name</u>	<u>Grades</u>
Preschool/Daycare:	_____	_____
Elementary:	_____	_____
	_____	_____
Middle School:	_____	_____
	_____	_____
High School:	_____	_____
	_____	_____

Has your child ever been retained or held back a grade?

Does your child receive special education services (IEP) or have a 504 Plan? (If so, please provide IEP/504)

Please list extracurricular activities which your child has participated in during the last six months:

Please list your child's most current grades/GPA: _____

Reading _____ History/ Social Studies _____ Writing _____
 Spelling _____ Math _____ Science _____

Please describe your child's study habits:

Have you noticed any changes in academic performance recently?

FAMILY HISTORY

Please list family history (child's siblings, parents, grandparents, aunts/uncles, cousins) for any of the following:

	None	Yes	Relation to Child
Seizure disorders			
Learning difficulties			
ADHD/ADD			
Depression/suicide attempts			
Bipolar Disorder/Manic Depression			
Tic disorders			
Anxiety difficulties			
Nervous breakdowns/Schizophrenia			
Substance use/Alcoholism/ Illegal prescriptions			
Autism/Aspergers/Pervasive Developmental Disorder			
Eating Disorders/Obesity			
Other medical			

PREGNANCY AND BIRTH HISTORY

This section is to be completed by the mother of the child, if possible. Please indicate if answered by another person: _____.

Number of living children _____

Number of deceased children _____

This child was the product of pregnancy number _____

	Yes	No	Comments
Did you have any health problems during pregnancy with this child? If yes, please describe the problem and the time it occurred during the pregnancy (such as infections, high blood pressure, diabetes, bleeding, weight loss, accidents, fever, etc.)			
Did you take any medication, smoke, drink, or use drugs during this pregnancy? If yes, please list.			
Was your baby carried less/more than nine months? If yes, please indicate the length of pregnancy.			
Were there any difficulties with delivery? If yes, please describe the problems (such as Cesarean section, slow heart rate, fever, etc.)			
How much did your baby weigh at birth?	_____ pounds, _____ ounces		
Did your baby need any special care during the first few hours/days after delivery? If yes, please describe.			
Did you have any difficulty caring for your child during the first few months of life? If yes, please describe.			

DEVELOPMENTAL HISTORY

	Yes	No	Comments
Was your child's development any faster or slower than that of other children? Please explain.			
At what age did your child sit alone?			
At what age did your child crawl?			
At what age did your child walk alone?			
At what age did your child make sounds?			

	Yes	No	Comments
At what age did your child say single words?			
At what age did your child combine words?			
Is your child toilet trained? If yes, age what age?			
Does your child have toileting accidents during the day? If yes, how often?			
Does your child have toileting accidents during the night? If yes, how often?			

Please describe your child as a toddler.

Sleeping and eating habits:

Separation anxiety:

Self-soothing activities:

Temperament:

Sensitivities to noise, touch, and/or taste:

LEARNING AND PSYCHOLOGICAL/MEDICAL INTERVENTIONS

Has your child received or been evaluated for any of the following?

	Yes	No	Dates	Where and/or Who
Educational/Psychological testing				
Speech/language therapy				
Physical therapy				
Occupational therapy				
Tutoring				
Counseling/ Psychiatry				
Restrictive Diet Supplements				
Other (please list)				

SOCIAL HISTORY

How does your child entertain him/herself? Please list hobbies or activities he/she enjoys:

Describe your child's interactions with family members:

Describe your child's interactions with peers:

Please describe your child's present peer group:

Please describe what you consider to be your child's strengths:

Do you have concerns regarding possible alcohol and/or drug use? _____ Yes _____ No _____ N/A

Please list your child's current medical providers, mental health providers or tutors.

Thank you