**Behavioral Health Associates of Western New York**

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**Psychosocial/Health Screening Questionnaire**

Dear Parent or Guardian:

We ask that you fill out the following paperwork **as completely as possible**. Your cooperation is necessary and much appreciated.

The purpose of this is to gather as much pertinent clinical history as possible so that the doctor treating your child can have a full understanding of his/her development and presenting problems.

Please keep in mind that some of the questions asked may not pertain to your child, yet they are important parts of a thorough evaluation. This evaluation is for the doctor to review. This form will not be sent to other agencies, but with your permission, a summarized dictation will be sent to treatment providers for continuity of care. Please list the name of the person filling out this form and the relationship to the child.

**NAME/RELATIONSHIP:**_____
_____

Please list all available phone numbers staff can use in order to contact you.

MOTHER'S NAME:_____

Home:_____ Cell:_____

Work:_____ Emergency:_____

FATHER'S NAME:_____

Home:_____ Cell:_____

Work:_____ Emergency:_____

EMERGENCY CONTACT'S NAME:_____

Home:_____ Cell:_____

Work:_____ Emergency:_____

We thank you for your time and effort.

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**HPI**

1. Please describe the problems that led to your bringing your child into treatment, and in particular, what led you to bring him/her at this time.

_____

_____

_____

_____

Has your child ever threatened to hurt himself or herself? Yes_____No_____

Describe_____

_____

Has your child ever intentionally hurt himself or herself? Yes_____No_____

Describe_____

_____

2. The child lives with (please check):

_____Biological parent(s)
_____Adoptive parent(s)
_____Group home/facility
_____Relatives
_____Foster Family

3. Who else lives in the home? (relationship)_____

_____

4. Has your child been in **outpatient therapy** for behavioral/emotional problems in the past or currently (include alcohol and/or drug treatment)? Yes_____ No_____
* If yes, please specify where, approximate dates and the effectiveness of the treatment.

| **Treatment Provider** | **Dates** | **Effectiveness** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

The diagnosis given to my child was _____

5. Has your child been **an inpatient in a hospital ward** for treatment of behavioral/emotional problems in the past?
Yes_____ No_____
* If yes, please specify where, approximate dates and the effectiveness of the treatment.

| Treatment provider | Dates | Effectiveness |
|---|---|---|
| | | |
| | | |
| | | |

6. Has your child taken medication in the past for behavioral/emotional problems?
Yes _____ No_____
* If yes, please list them, describe the effectiveness and list doses, as well as any side effects if recalled.

| Medication | Dose | Side Effects | Effectiveness |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

7. Is your child taking any medications at this time for behavioral or emotional problems?
Yes_____ No_____
* If yes, please list the names of the medication and dosage.

| Medication | Dose |
|---|---|
| | |
| | |
| | |
| | |

Are the medications secured? Yes_____No_____

Explain:_____

**Medical History**
Please list the name and phone number of your child 's pediatrician.
Name/phone number:_____

8. Does your child have any allergies to medication or environmental allergies? Yes_____No____
* If yes, please list them as well as the **specific reaction**.

| Allergy (Medication/Environmental) | Reaction |
|---|---|
| | |
| | |
| | |

9. Does your child have any medical problem for which he/she is followed? Yes_____No_____

Explain:_____

_____

10. Has your child ever been admitted to a hospital because of medical problems, including illness or injury? Yes_____No_____
*If yes, please provide details including the reason for admission, the age of the child at the time of admission and the outcome.

| **Hospital** | **Date** | **Age** | **Reason** | **Outcome** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

11. Are your child's immunizations up to date? Yes_____No_____

*If no, explain:_____

12. Is your child taking any prescription or over-the-counter medications for a medical condition at this time (include contraception)? Yes_____No_____

| **Medication** | **Dose** |
|---|---|
| | |
| | |
| | |

How much caffeine does your child use? (Include soda pop, coffee, tea, etc)_____

13. Has your child had **surgery** for any reason? Yes_____No_____
*If yes, please provide details including the surgical procedure, age of the child at the time of admission and outcome.

| **Surgery** | **Age** | **Outcome** |
|---|---|---|
| | | |
| | | |
| | | |

**Review of Systems**

14. Does your child have or have they ever had any problems as described below?
*If yes, please provide details.

| | Yes | No | Comment |
|---|---|---|---|
| General weight loss | | | |
| Fever, sweating | | | |
| Recent illness (including strep) | | | |
| History of exposure to toxins/lead | | | |
| Skin condition | | | |
| Head injury | | | |
| Frequent headaches | | | |
| Vision problems | | | |
| Hearing problems | | | |
| Dental problems | | | |
| Asthma/shortness of breath | | | |
| Heart condition | | | |
| Stomach/gastrointestinal problems | | | |
| Hepatitis/jaundice | | | |
| Frequent urinary tract infection (bladder infection) | | | |
| Bedwetting | | | |
| Sleep problems | | | |
| Accidental bowel movement | | | |
| Joint pain/swelling | | | |
| Muscle pains | | | |
| Seizures | | | |
| Muscle twitches/tics | | | |
| Bleeding problems/easy bruising | | | |
| Anemia | | | |
| Endocrine problems (diabetes, thyroid, problems with menses) | | | |
| ** For girls, date of menses started | | | |

During what hours does your child sleep?_____

**Developmental History**

15. Please answer the following questions about your child's development:

a. Was the pregnancy planned? Yes_____No_____
Mother's age at time of pregnancy:_____ Father's age at time of pregnancy:_____

b. Did both biological parents live together at the time of conception? Yes_____No_____

c. What were mother and father's reactions to finding out about the pregnancy?

_____

_____

d. How would you describe the relationship between the biological parents during the pregnancy?

_____

e. During the pregnancy, did mother:

| | **Yes** | **No** | **Type** | **Amount** |
|---|---|---|---|---|
| Smoke cigarettes | | | | |
| Use alcohol | | | | |
| Use prescription drugs | | | | |
| Use street drugs | | | | |

f. During the pregnancy, did mother have:

| | **Yes** | **No** | **Describe** |
|---|---|---|---|
| Exposure to x-rays | | | |
| Excessive bleeding | | | |
| Illness of any type | | | |
| Trauma/accidents | | | |
| Premature labor | | | |

g. During the pregnancy, mother gained _____ pounds.

h. Was the baby delivered vaginally? Yes_____No_____
Or by C-section? Yes_____No_____

i. Was the baby full-term? Yes_____ No_____
Describe:_____

j. Were there any complications with the delivery? Yes_____ No_____
Or shortly afterwards? If yes, please describe:_____

_____

k. During your child's early development, were there:

- Any speech delays? Yes_____ No_____

Describe:_____

_____

- Any delays in motor development/walking? Yes _____ No_____

Describe:_____

_____

l. At what age did your child use 2 word sentences? _____

m. Did your child ever need speech therapy? Yes _____ No_____

n. At what age did your child walk?_____

o. At what age was your child toilet trained? Bladder _____ Bowel _____

p. Who was involved in taking care of the baby in the first three years of life?

_____

q. Was the baby separated from the primary caregiver for any length of time?
Yes _____ No_____
Describe: _____

r. How would you describe your child as a baby/toddler?

| | **Yes** | **No** | **Describe** |
|---|---|---|---|
| Difficult to manage | | | |
| Easy going | | | |
| Shy/Slow to warm up | | | |

s. Did mother bond well with the baby? Yes_____ No_____
Describe:_____

_____

t. Did father bond well with the baby? Yes _____ No_____
Describe:_____

_____

u. During any time in your child's life, has he/she been a victim of physical or sexual abuse to your knowledge? Yes _____ No_____
Describe:_____

_____

v. Has your child ever been exposed to potentially traumatic events such as severe accidents to self or others, domestic violence, police involvement with family etc?
Yes _____ No _____ Explain:_____

_____

w. Has Child Protective Services ever been involved with the family? Yes _____ No_____
Explain: _____

_____

**School History**

16. Please answer the following questions about your child's schooling.

a. Did your child go to preschool or Head Start? Yes _____ No _____

b. At what age did your child start kindergarten? _____

c. Has your child ever had to repeat a grade? Yes _____ No _____
If yes, please provide details: _____

_____

d. Has your child ever been in special education? Yes _____ No _____
If yes, please provide details: _____

_____

e. Does your child have an Individualized Education Plan (IEP)? Yes _____ No _____

f. Has your child ever been considered to have an emotional disturbance according to the school?
Yes _____ No_____
Describe:_____

_____

g. Has your child ever had a learning disorder? Yes _____ No _____
Describe:_____

_____

h. How would you describe your child's academic performance?
_____

_____

i. How would you describe your child's general behavior at school?

_____

j. Has your child ever had a history of refusing to attend school or excessive absences?
Yes _____ No _____ Describe:_____

_____

k. Has your child ever skipped school? Yes _____ No _____ Describe:_____

_____

l. What is the name of your child's school and what grade is he/she in? _____

_____

**Social History**

17. Please answer the following questions about your child's social history:

a. How old is mother? _____ b. Mother's educational level: _____

c. Is mother employed? Yes _____ No _____
Describe:_____

d. Work hours? _____

e. How old is father? _____ f. Father's educational level: _____

g. Is father employed? Yes _____ No _____
Describe: _____

h. Work hours? _____

i. Please list the ages and grades of the siblings:

| **First** | **Last** | **Grade** | **Relationship Full/Half/Step/Foster** | **Age** | **Lives at home?** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

j. Are there any current family stressors? Yes _____ No _____
Describe: _____

Is there a history of:

| | **Yes** | **No** | **Describe** |
|---|---|---|---|
| Moving? | | | |
| Death of a parent/primary caregiver? | | | |
| Death of a close relative? | | | |
| Divorce? | | | |

If the parents divorced, how old was the child at the time of the divorce and what was his/her reaction to it?
_____

k. What does your child do with leisure time? Please list any sports, interests, clubs, hobbies, etc.
_____

_____

l. How many hours per day does your child spend:

a. Watching TV? _____

b. Playing video games? _____

c. On the Internet? _____

m. How well does your child socialize with peers? _____

_____

n. What does your child do in the company of peers? _____

_____

o. Is your child dating yet? Yes _____ No _____

p. To your knowledge, has your child been sexually active? Yes _____ No _____

q. Does your child have any history of the following?

| | **Yes** | **No** | **Describe** |
|---|---|---|---|
| Placement or PINS | | | |
| Arrests | | | |
| Probation | | | |
| Theft | | | |
| Running away from home overnight or longer | | | |
| Violence towards other or property | | | |
| Violence towards self | | | |
| Fire setting | | | |
| Cruelty to animals | | | |
| Alcohol use | | | |
| Illegal drug use | | | |
| Cigarette use | | | |
| Access to firearms | | | |
| Sexually inappropriate behavior | | | |
| Placement out of the home | | | |

r. Are there firearms in the home? Yes _____ No _____

Describe: _____

_____

**Family History**

18. Has any member of the immediate family or extended biological family ever suffered from any type of mental illness or disruptive behavior problems? (Please include both the biological mother and father's family history including history of):

| History of | Yes | No | Describe |
|---|---|---|---|
| Depression | | | |
| Bipolar disorder/Manic Depression | | | |
| Suicide/Suicide Attempt | | | |
| Anxiety | | | |
| Obsessive Compulsive Disorder | | | |
| Attention Deficit Disorder | | | |
| Dementia/Alzheimer's | | | |
| Psychosis/Schizophrenia (hearing things/delusions) | | | |
| Alcohol Problems | | | |
| Illegal Drug Problems | | | |
| Arrests/Criminal Behavior | | | |
| Abuse | | | |
| Learning Problems | | | |
| Autism | | | |
| Tourette Disorder | | | |
| Eating Disorder (Anorexia/Bulimia) | | | |
| Personality Disorder | | | |

19. Has any member of the immediate or biological family ever suffered from any type of medical illness?

Yes _____ No _____

a. Please describe what illness and how they are related? _____

_____

20. List 5 "triggers" that tend to upset your child:

1._____

2._____

3._____

4. _____

5._____

21. List 5 things that tend to calm/soothe your child:

1._____

2._____

3._____

4._____

5._____

22. List things that you do together as a family:_____

_____

_____

23. List the main strengths and supports of the family:

Strengths:

1._____

2._____

3._____

Supports:

1._____

2._____

3._____

24. What would you describe as your child's 5 biggest strengths?

1._____

2._____

3._____

4._____

5._____

25. What do you hope to see for your child as a result of treatment?

_____

_____

Thank you for your time.