NORTH ALABAMA FAMILY PSYCHIATRY & COUNSELING

Child & Adolescent Initial Assessment
Parent Questionnaire

Patient Name: _____ **Date:** _____
Age: _____ **Date of Birth:** _____/_____/_____
Name of person completing this form: _____

Relationship to Patient: _____

Please read the following questions and answer to the best of your ability by placing a checkmark in the appropriate boxes or filling in the blank as directed. Your cooperation is appreciated.

NOTE: IF PATIENT IS *12yo OR OLDER*, HAVE THEM FILL OUT THE ADOLESCENT QUESTIONNAIRE TOO.
Referred by: _____

Please describe, in detail, the present problem including when the problem started, how often it occurs and what stressors may contribute to the problem.

_____
_____
_____
_____
_____
_____
_____
_____

Has your child received any previous treatment for the problem? □ Yes □ No If yes, explain:

_____
_____

Past Medical History:

Allergies_____
Primary Care Physician_____Phone#_____
Date and place of last physical exam: _____

Please check any of the following medical conditions for which your child was ever evaluated or diagnosed with, including non-psychiatric hospitalizations or surgeries:

□ Seizures	□ Heart Problems	□ Weight Problems	□ Head Injury
□ Asthmatic condition	□ Chronic Fatigue	□ Chronic Headaches	□ Depression
□ Chronic Hearing Loss	□ Stomach Problems	□ Suicidal Thoughts	□ Surgeries

□ Other _____
_____

List ALL current prescription medications and how often you take them: (if none, write none)

_____
_____
_____
_____
_____

Current over-the-counter medications or supplements:

_____
_____

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Developmental History:

A: Relating to your child's birth:

Your child's weight at birth: ____lbs. ____oz. Was this a full term birth? □ Yes □ No If no, explain: _____

_____

Did either parent use drugs or alcohol at the time of conception? □ Yes □ No If yes, explain:

_____

Were there any complications with the labor & delivery such as jaundice, infection etc.?

□ Yes □ No If yes, explain: _____

_____

Were there any problems after birth? □ Yes □ No If yes, explain: _____

_____

B. Pre-school/Toddler Temperament: Please check the following items that apply.

□ Did not enjoy being held	□ Excessive restlessness	□ Colic
□ Feeding problems	□ Sleep problems	□ Head-banging
□ Sensitive to light / noise / texture	□ Fussy or unhappy	□ Difficulty bonding

C. Developmental Milestones: Please indicate the approximate age in months when your child achieved the following tasks:

_____ Sitting alone _____ Walking _____ Put words together _____Toilet trained

D. Unusual behaviors/Speech patterns:

□ Spinning □ Putting things in the mouth □ Repeating words or phrases inappropriately

□ Hand flapping □ Sniffing excessively □ Saying "I" for "You"

Psychiatric History:

Does your child have a prior psychiatric diagnosis? If so, what is it and when did they receive it?

_____

_____

_____

_____

Outpatient treatment or psych testing: □ Yes □ No

If yes, describe by whom, when, and the nature of treatment.

By Whom Dates Treated Reason

_____

_____

_____

_____

Psychiatric Hospitalization: □ Yes □ No If yes, describe where, when and for what reason.

Where Dates Hospitalized Reason

_____

_____

_____

_____

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Past Psychiatric Medications: Please list all psychiatric medications your child has ever been prescribed.

_____

_____

_____

_____

If your child has ever taken any of the following medications, please check them and indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember)

Dates Dosage Response/Side-Effects

Antidepressants

□ Prozac (fluoxetine) _____
□ Zoloft (sertraline) _____
□ Luvox (fluvoxamine) _____
□ Paxil (paroxetine) _____
□ Celexa (citalopram) _____
□ Lexapro (escitalopram) _____
□ Effexor (venlafaxine) _____
□ Pristiq (desvenlafaxine)_____
□ Cymbalta (duloxetine) _____
□ Fetzima (levomilnacipran)_____
□ Brintellix (vortioxetine)_____
□ Wellbutrin (bupropion) _____
□ Viibryd (vilazodone)_____
□ Remeron (mirtazapine) _____
□ Serzone (nefazodone) _____
□ Anafranil (clomipramine) _____
□ Pamelor (nortrptyline) _____
□ Tofranil (imipramine) _____
□ Elavil (amitriptyline) _____
□ Other _____

Mood Stabilizers

□ Tegretol (carbamazepine)_____
□ Lithium_____
□ Depakote (valproate) _____
□ Lamictal (lamotrigine) _____
□ Tegretol (carbamazepine) _____
□ Topamax (topiramate) _____
□ Other _____

Antipsychotics/Mood Stabilizers

□ Haldol (haloperidol)_____
□ Prolixin (fluphenazine)_____
□ Risperdal (risperidone)_____
□ Seroquel (quetiapine)_____
□ Geodon (ziprasidone)_____
□ Clozaril (clozapine)_____

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Dates Dosage Response/Side-Effects

□ Invega (paliperidone)_____
□ Abilify (aripiprazole)_____
□ Zyprexa (olanzapine)_____
□ Saphris (asenapine)_____
□ Fanapt (iloperidone)_____
□ Latuda (lurasidone)_____
□ Rexulti (brexpiprazole)_____
□ Vraylar (cariprazine) _____
□ Other _____

Anxiolytics

□ Vistaril/Atarax (hydroxyzine)_____
□ BuSpar (buspirone)_____
□ Xanax (alprazolam)_____
□ Ativan (lorazepam)_____
□ Valium (diazepam) _____
□ Klonopin (clonazepam)_____
□ Other _____

Sedative/Hypnotics

□ Ambien (zolpidem) _____
□ Sonata (zaleplon) _____
□ Rozerem (ramelteon)_____
□ Silenor (doxepin)_____
□ Restoril (temazepam) _____
□ Desyrel (trazodone) _____
□ Other _____

ADHD medications

□ Adderall or XR (dextroamphetamine/amphetamine)_____
□ Ritalin or LA/SR (methylphenidate)_____
□ Concerta (methylphenidate) _____
□ Methylphenidate ER_____
□ Focalin or XR (dexmethylphenidate)_____
□ Daytrana (methylphenidate transdermal)_____
□ Vyvanse (lisdexamphetamine)_____
□ Mydayis (dextroamphetamine/amphetamine)_____
□ Aptensio XR (methylphenidate)_____
□ Quillivant XR (methylphenidate)_____
□ Evekeo (amphetamine)_____
□ Tenex (guanfacine)_____
□ Intuniv (guanfacine ER)_____
□ Catapres (clonidine)_____
□ Kapvay (clonidine ER)_____
□ Strattera (atomoxetine)_____
□ Other _____

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Family Psychiatric History: Has anyone in your child's family been diagnosed with or treated for:

Bipolar disorder	□ Yes □No	Schizophrenia	□ Yes □ No
Depression	□ Yes □ No	Post-traumatic stress	□ Yes □ No
ADHD	□ Yes □ No	Learning Disability	□ Yes □ No
Autism	□ Yes □ No	Intellectual Disability	□ Yes □ No
Anxiety	□ Yes □ No	Alcohol abuse	□ Yes □ No
Anger	□ Yes □ No	Other substance abuse	□ Yes □ No
Suicide	□ Yes □ No	Violence	□ Yes □ No

If yes, who had each problem?

_____
_____
_____
_____

Family Background and Childhood History:

Was your child adopted? □ Yes □ No If yes, at what age? _____
Biological mothers' full name: _____
Biological fathers' full name: _____

Parents' marital status: □ Married □ Separated □ Divorced □ Never married
If divorced from one another, has either remarried? Mother □ Yes □ No
Father □ Yes □ No
If the parents are divorced or separated, who has custody of the patient? _____
What is the custody arrangement? _____
Stepmothers' name: _____
Stepfathers' name: _____

List all relatives who presently live in the same household as your child (if more than 5 please list on back of this sheet):

Name	Relationship	Employment or Grade Level/Age
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

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Legal / Juvenile Court / Alabama State Department of Human Resources (DHR):
Has your child been:
arrested? □ Yes □ No
assigned a probation officer? □ Yes □ No If yes, their name: _____
jailed? □ Yes □ No
Has your child:
ever appeared in juvenile court? □ Yes □ No
or other family member ever been reported to DHR? □ Yes □ No
been assigned a DHR caseworker? □ Yes □ No
If yes, their name: _____
ever been a victim of child physical or sexual abuse? □ Yes □ No

If you answered yes to any of these questions, please explain: _____
_____
_____

School/Daycare History:
Did your child attend daycare? □ Yes □ No If yes, at what age? _____ Any problems? _____
What were your child's grades on their last report card? _____
What is the name of your child's primary teacher? _____

Name of **Current School:**	Dates Attended	Present Grade Placement	Behavior Problems	Learning Problems
_____	_____	_____	□ Yes □ No	□ Yes □ No

Name of **Past Schools:**	Dates Attended	Present Grade Placement	Behavior Problems	Learning Problems
_____	_____	_____	□ Yes □ No	□ Yes □ No
_____	_____	_____	□ Yes □ No	□ Yes □ No
_____	_____	_____	□ Yes □ No	□ Yes □ No

Has your child ever been:
evaluated for a learning disability? □ Yes □ No If yes, what grade? _____ When?_____

placed in Special Education Classes? □ Yes □ No If yes, what type of class? _____
_____

tested by the school system? □ Yes □ No If yes, when? _____

expelled or suspended? □ Yes □ No If yes, please describe: _____
_____
Does your child have a current IEP (Individual Education Plan)? □ Yes □ No
Does your child have a current 504 plan? □ Yes □ No