GENERAL INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE

As part of processing your request for an evaluation of your child, we would like you to complete the enclosed form about your child and your family. Your answers will give Dr. Simpson a much better understanding of your child's behavior at home and your family circumstances.

1. This questionnaire should be completed by the parent or legal guardian who has the primary responsibility for caring for this child. Where both parents reside with the child, this should be the parent who spends the greatest amount of time with the child.
2. If your child is already taking medication for assistance with his/her behavior management (such as Ritalin) or for any emotional difficulties (such as an antidepressant), we must ask that you complete the questionnaires about your child's behavior based on how your child behaves when he/she is OFF this medication. It is very likely that you occasionally observe your child's behavior at periods when he/she is off of this medication, and we want you to use those time periods to answer these questions about behavior. In this way, we can get a clearer idea of the true nature of your child's difficulties without the alterations produced by any medication treatments being used. However, some parents whose children have been on medication for a long time may not be able to give us this information. In that case, just complete the questionnaires based on your child's behavior, but check the third square below to let us know that you based your judgments on your child's behavior when he/she was on medication. Check one of the blanks below to let us know for certain on what basis you judged your child's behavior in answering our behavior questionnaires:

☐ My child currently does not take any medication for behavior problems, my answers are based on my child's behavior while he/she is off of medication.

☐ My child is currently taking medication for behavior problems. However, my answers are based on my child's behavior while he/she is OFF of this medication.

☐ My child is currently taking medication for behavior problems. My answers are based on my child's behavior while he/she is ON this medication.

Please list any medications your child is currently taking for behavioral or emotional difficulties:

THANK YOU FOR COMPLETING THESE FORMS. PLEASE BRING THIS COMPLETED QUESTIONNAIRE WITH YOU TO YOUR NEXT SESSION WITH DR. SIMPSON. IF YOUR CHILD IS IN-PATIENT, HAVE THE UNIT NURSE PLACE THE FORMS IN YOUR CHILD'S FILE.

PARENT REPORT FORM

Child's name _____ **Informant** _____

Informant's relationship to child: ☐ Mother ☐ Father ☐ Other: _____

Child's date of birth _____ Age: Years _____ Months _____ Today's Date _____

FAMILY COMPOSITION

Is this child: ☐ Your biological child ☐ Adopted ☐ Foster child

With which parent does the child live?

☐ Both ☐ Mother only ☐ Father only

☐ Neither parent; child lives with ☐ Grandparent ☐ In foster care

Do you have legal custody of this child? ☐ Yes ☐ No

Does any other adult live in the home? ☐ Yes ☐ No If so, who is it? _____

Address _____

(Street) (City) (State) (Zip)

Home phone ( ) _____ Work phone ( ) _____ Dad / Mom

(Circle one)

Child's school _____ Primary Teacher's name _____

School address _____

(Street) (City) (State) (Zip)

School phone ( ) _____ Child's grade _____

Is child in special education? ☐ Yes ☐ No If so, what type?_____

Father's name _____ Age _____ Education _____

Father's place of employment _____

Type of employment _____

Mother's name _____ Age _____ Education _____

Mother's place of employment _____

Type of employment _____

Is child adopted? ☐ Yes ☐ No If yes, age when adopted _____

Are parents married? ☐ Yes ☐ No Separated? ☐ Yes ☐ No Divorced? ☐ Yes ☐ No

Child's physician _____

Physician's address _____

(Street) (City) (State) (Zip)

Physician's telephone number _____

Please list all other children in the family,

Name	Age	School grade

DEVELOPMENTAL AND MEDICAL HISTORY

PREGNANCY AND DELIVERY FOR THIS CHILD

A. Length of pregnancy (e.g., full term, 40 weeks, 32 weeks, etc.)	
B. Length of delivery (number of hours from initial labor pains to birth)	
C. Mother's age when child was born	
D. Child's birth weight	

E. Did any of the following conditions occur during pregnancy/delivery?

1. Bleeding	No	Yes
2. Excessive weight gain (more than 30 lbs.)	No	Yes
3. Toxemia/preeclampsia	No	Yes
4. Rh factor incompatibility	No	Yes
5. Frequent nausea or vomiting	No	Yes
6. Serious illness or injury	No	Yes
7. Took prescription medications a.. If yes, name of medication _____	No	Yes
8. Took illegal drugs	No	Yes
9. Used alcoholic beverage a.. If yes, approximate number of drinks per week _____	No	Yes
10. Smoked cigarettes a. If yes, approximate number of cigarettes per day (e. g., 1/2 pack) _____	No	Yes
11. Was given medication to ease labor pains a.. If yes, name of medication _____	No	Yes
12. Delivery was induced	No	Yes
13. Forceps were used during delivery	No	Yes
14. Had a breech delivery	No	Yes
15. Had a cesarean section delivery	No	Yes
16. Other problems-please describe _____ _____	No	Yes

F. Did any of the following conditions affect your child during delivery or within the first few days after birth?

1. Injured during delivery	No	Yes
2. Cardiopulmonary distress during delivery	No	Yes
3. Delivered with cord around neck	No	Yes
4. Had trouble breathing following delivery	No	Yes
5. Needed oxygen	No	Yes
6. Was cyanotic, turned blue	No	Yes
7. Was jaundiced, turned yellow	No	Yes
8. Had an infection	No	Yes
9. Had seizures	No	Yes
10. Was given medications	No	Yes
11. Born with a congenital defect	No	Yes
12. Was in hospital more than 7 days	No	Yes

INFANT HEALTH AND TEMPERAMENT

A. During the first 12 months, was your child:

1. Difficult to feed	No	Yes
2. Difficult to get to sleep	No	Yes
3. Colicky	No	Yes
4. Difficult to put on a schedule	No	Yes
5. Alert	No	Yes
6. Cheerful	No	Yes
7. Affectionate	No	Yes
8. Sociable	No	Yes
9. Easy to comfort	No	Yes
10. Difficult to keep busy	No	Yes
11. Overactive, in constant motion	No	Yes
12. Very stubborn, challenging	No	Yes

EARLY DEVELOPMENTAL MILESTONES

A. At what age did your child first accomplish the following:

1. Sitting without help	
2. Crawling	
3. Walking alone, without assistance	
4. Using single words (e.g.,"mama," "dada", "ball," etc.)	
5. Putting two or more words together (e.q.,"mama up")	
6. Bowel training, day and night	
7. Bladder training, day and night	

HEALTH HISTORY

A. Date of child's last physical exam: _____

B. At any time has your child had the following:

1. Asthma	Never	Past	Present
2. Allergies	Never	Past	Present
3. Diabetes, arthritis, or other chronic illnesses	Never	Past	Present
4. Epilepsy or seizure disorder	Never	Past	Present
5. Febrile seizures	Never	Past	Present
6. Chicken pox or other common childhood illnesses	Never	Past	Present
7. Heart or blood pressure problems	Never	Past	Present
8. High fevers (over 103")	Never	Past	Present
9. Broken bones	Never	Past	Present
10. Severe cuts requiring stitches	Never	Past	Present
11. Head injury with loss of consciousness	Never	Past	Present
12. Lead poisoning	Never	Past	Present
13. Surgery	Never	Past	Present
14. Lengthy hospitalization	Never	Past	Present
15. Speech or language problems	Never	Past	Present
16. Chronic ear infections	Never	Past	Present
17. Hearing difficulties	Never	Past	Present
18. Eye or vision problems	Never	Past	Present
19. Fine motor/handwriting problems	Never	Past	Present
20. Gross motor difficulties, clumsiness	Never	Past	Present
21. Appetite problems (overeating or undereating)	Never	Past	Present
22. Sleep problems (falling asleep, staying asleep)	Never	Past	Present
23. Soiling problems	Never	Past	Present
24. Wetting problems	Never	Past	Present
25. Other health difficulties-please describe	Never	Past	Present

PARENTAL CONCERNS ABOUT CHILD / REASONS FOR EVALUATION

What are you most concerned about regarding your child that led you to request this evaluation?

Home behavior management problems:

Home emotional reaction problems:

Developmental delays:

School behavior management problems:

School work performance or learning problems:

School emotional reaction problems:

Social interaction problems with peers:

Behavior in the community (outside of home and school):

Other concerns:

Why have you decided to seek this evaluation of your child at this time?

What type of assistance or treatment recommendations do you hope to receive from this evaluation?

Now I need to go over a number of different topics with you about your child. This needs to be done to be sure that I get as comprehensive a picture of your child's psychological adjustment as possible. I am going to ask you about a number of important developmental areas for any child. You should tell me if you have noticed anything unusual, abnormal, atypical, or even bizarre about your child's functioning in any of these areas. Let's begin with your child's:

Sensory development (impairments in vision, hearing, sense of touch or smell; abnormal reactions to sensory
stimulation; hallucinations, etc.):

Motor development (coordination, gait, balance, pasture, movements, gestures, tics, nervous habits or
mannerisms, etc.):

Language development (delays, comprehension problems, speech difficulties):

Emotional development (overreactions, mood swings, extreme or unpredictable moods, peculiar or odd
emotions, unusual fears or anxieties, etc.):

Thinking (odd ideas, bizarre preoccupations or fixations, unusual fantasies, speaks in incomplete or incoherent
thoughts, delusions):

Social behavior (aggressive, rejected, bullies others, withdrawn, shy, anxious around others, mute when with others, aloof from others or shows no desire for friends/playmates, etc.).

Intelligence/academic skills (delays in general mental development; problems with memory; or specific delays in reading, math, spelling, handwriting, or other academic skill areas):

Additional comments/information:

REVIEW OF DSM-IV CHILDHOOD DISORDERS

Now I need to ask you about a number of very specific questions about a variety of behavioral, social, or emotional problems that children sometimes have difficulties with. As I ask you about these things, keep in mind that some of these things are not bad or abnormal and may be seen sometimes in healthy, normal children. I want you to tell me if your child does any of these things to a degree that you consider to be inappropriate for someone of his/her age and sex.

Oppositional Defiant Disorder

I am now going to ask you some specific questions about your child's behavior during the past 6 months. For each of the behaviors I ask you about, please tell me if your child shows that behavior to a degree that is inappropriate compared to other children of your child's age.

During the past 6 months, did your child show any of the following:

A. Oppositional Defiant List

	Yes	No	Unknown
1. Often loses temper			
2. Often argues with adults			
3. Often actively defies or refuses to comply with adults' requests or rules			
4. Often deliberately annoys people			
5. Often blames others for his/her own mistakes or misbehavior			
6. Is often touchy or easily annoyed by others			
7. Is often angry or resentful			
8. Is often spiteful or vindictive			

B. Have these behaviors existed for at least the past 6 months? ☐ Yes ☐ No ☐ Unknown

C. At what age did these behaviors first cause problems for your child? _____ (yrs.)

D. Have these behaviors created problems or impairment for your child in either of the following areas

	Yes	No	Unknown
Social relations with others			
Academic performance			

Conduct Disorder

Now I want to ask you about some other things your child may have done. For these behaviors, I want you to think about the past 12 months and tell me whether any of these have occurred during that time.

A. Conduct Disorder List

During the past 12 months, did your child do any of the following:

	Yes	No	Unknown
1. Often bullies, threatens, or intimidates others			
2. Often initiates physical fights			
3. Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, or gun)			
4. Has been physically cruel to people			

	Yes	No	Unknown
5. Has been physically cruel to animals			

6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)			
7. Has forced someone into sexual activity			
8. Has deliberately engaged in fire setting with the intention of causing serious damage			
9. Has deliberately destroyed others' property (other than by fire setting)			
10. Has broken into someone else's house, building, or car			
11. Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)			
12. Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)			
13. Often stays out at night despite parental prohibitions. If so, at what age did this begin? _____ (yrs.)			
14. Has run away from home overnight at least twice while living in parent's home, foster care, or group home If so, how many times? _____			
15. Is often truant from school If so, at what age did he/she begin doing this? _____ (yrs.)			

B. Have three of these behaviors occurred during the past 12 months? ☐ Yes ☐ No ☐ Unknown

C. Has at least one of these behaviors occurred during the past 6 months? ☐ Yes ☐ No ☐ Unknown

D. Did any of these behaviors occur prior to age 10 years? ☐ Yes ☐ No ☐ Unknown

E. Have these behaviors created problems or impairment for your child in either of the following areas?

	Yes	**No**	**Unknown**
Social relations with others			
Academic performance			

Attention - Deficit/ Hyperactivity Disorder

Let me ask you about some other behaviors that your child may have shown during the past 6 months. Again, for each of the behaviors I ask you about, please tell me if your child shows that behavior to a degree that is inappropriate compared to other children of your child's age.

A. Inattention List

During the past 6 months, did your child show any of the following:

	Yes	**No**	**Unknown**
1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities			
2. Often has difficulty sustaining attention in tasks or play activities			
3. Often does not seem to listen when spoken to directly			

	Yes	No	Unknown
4. Often does not follow through on instructions and falls to finish schoolwork, chores, or duties at work			
5. Often has difficulty organizing tasks and activities			
6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)			
7. Often loses things necessary for tasks or activities (e,g., toys, school assignments, pencils, books, or tools)			
8. Is often easily distracted by extraneous stimuli			
9. Is often forgetful in daily activities			

B. Hyperactive-Impulsive

During the past 6 months, did your child show any of the following:

	Yes	No	Unknown
1. Often fidgets with hands or feet or squirms in his/her seat			
2. Often leaves his/her seat in the classroom or in other situations in which remaining seated is expected			
3. Often runs about or climbs excessively in situations in which it is inappropriate to do so			
4.Often has difficulty playing or engaging in leisure activities quietly			
5. Is often "on the go" or often acts as if "driven by a motor"			
6. Often talks excessively			
7. Often blurts out answers before questions have been completed			
8. Often has difficulty awaiting his/her turn			
9. Often interrupts or intrudes on others (e.g., butts into conversations or games)			

C. Have these behaviors existed for at least the past 6 months ☐ Yes ☐ No ☐ Unknown

D. At what age did these behaviors first cause problems for your child? _____ (yrs.)

E. During the past 6 months, have these behaviors caused problems for this child in any of these situations?

	Yes	No	Unknown
At home			
In school			
At daycare or babysitters			
In community activities (clubs, sports, scouts, etc.)			

F. Have these behaviors created problems or impairment for your child in any of the following areas?

	Yes	No	Unknown
Social relations with others			
Academic performance			

ANXIETY AND MOOD DISORDERS

Now I would like to ask you some questions about your child's emotions in general and his/her emotional reactions to some specific situations. I'll begin by asking you about any specific fears that your child may have. Then I will ask you about his/her general mood or emotional condition throughout much of the day. Let's start with some specific fears that your child may have.

Specific Phobia

A. Does your child show a marked and persistent fear that is excessive or unreasonable in response to the presence of or the anticipation of a specific object or situation? For instance, in response to or anticipation of certain animals, heights, being in the dark, thunderstorms or lightning, flying, receiving an injection, seeing blood, or any other things or situations? ☐ Yes ☐ No ☐ Unknown

If you responded yes to "A", answer B through G below, otherwise, skip to the next disorder.

What specifically is your child fearful of? _____

B. Does your child have this anxious or fearful reaction almost invariably when exposed to (specific thing or situation)? ☐ Yes ☐ No ☐ Unknown

C. Does your child attempt to avoid this thing or situation, or, if he/she must be exposed to it, does he/she endure it with intense anxiety or distress? ☐ Yes ☐ No ☐ Unknown

D. Does your child's avoidance of, anticipation of, or anxious reaction to this thing or situation interfere significantly with any of the following? ☐ Yes ☐ No ☐ Unknown

	Yes	**No**	**Unknown**
His/her normal routine			
Academic functioning			
Social activities			
Social relationships			

E. Does having this fear cause him/her marked distress? ☐ Yes ☐ No ☐ Unknown

F. Has your child had this fearful or anxious reaction to this thing or event over a period of at least the past 6 months? ☐ Yes ☐ No ☐ Unknown

Social Phobia

What about social situations?

A. General

1. Does your child show a marked and persistent fear that is excessive or unreasonable in response to the presence of or the anticipation of a social or performance situation in which he/she is exposed to unfamiliar people or to possible scrutiny by others? ☐ Yes ☐ No ☐ Unknown

2. Does your child fear that he/she will act in a way that will be embarrassing or humiliating or will be so anxious that it will be humiliating or embarrassing for him/her? ☐ Yes ☐ No ☐ Unknown

If you answered "yes" to <u>both</u> parts 1 and 2 above, answer the next question and then proceed with remaining criteria below, otherwise, skip to the next disorder.

3. What specific social situation is your child fearful of? _____

_____

B. Does your child have this anxious or fearful reaction almost invariably when exposed to this situation?
☐ Yes ☐ No ☐ Unknown

C . Does your child attempt to avoid this situation or, if he/she must be exposed to it, does he/she endure it with intense anxiety or distress? ☐ Yes ☐ No ☐ Unknown

D. Does your child's avoidance of, anticipation of, or anxious reaction to this situation interfere significantly with any of the following?

	Yes	No	Unknown
His/her normal routine			
Academic functioning			
Social activities			
Social relationships			

E. Does having this fear cause him/her marked distress? ☐ Yes ☐ No ☐ Unknown

F. Has your child had this fearful or anxious reaction to this situation for at least the past 6 months
☐ Yes ☐ No ☐ Unknown

Separation Anxiety Disorder

A. Separation Anxiety Disorder Symptom List

Now let's talk about how your child reacts emotionally when he/she must be away from you or when he/she must leave home for activities in the community. Does your child show any of the following?

	Yes	No	Unknown
1. Recurrent, excessive distress when separation from home, or from a parent or major attachment figures, occurs or is anticipated			
2. Persistent and excessive worry about losing a parent or major attachment figure or about possible harm occurring to such a figure			
3. Persistent and excessive worry that an unexpected or untoward event will lead him/her to become separated from a parent or major attachment figure (e.g., getting lost or being kidnapped)			
4.Persistent reluctance or refusal to go to school or elsewhere because of fear of separation			
5. Persistent and excessive fear or reluctance to be alone, or without a parent or major attachment figure at home, or without such a parent or caregiver when in other settings			
6. Persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home			

	Yes	No	Unknown
7. Repeated nightmares involving the theme or topic of separation from a parent or other caregiver			

8. Repeated complaints of physical symptoms, such as headaches, stomachaches, nausea, or vomiting, when separation from a parent or major attachment figure occurs or is anticipated			

If three or more symptoms were endorsed, proceed with remaining questions in this section; otherwise, skip to next disorder.

B. Have these fears existed for at least 4 weeks? ☐ Yes ☐ No ☐ Unknown

C. At what age did these behaviors first cause problems for your child? _____ (yrs.)

D. Have these worries created distress for your child or impairment in any of the following areas

	Yes	**No**	**Unknown**
Social relations with others			
Academic performance			
Any other areas of functioning			

Generalized Anxiety Disorder

Now let's talk about whether your child tends to be generally anxious or to worry a lot compared to other children of his/her age group.

A. General

1. Does your child show excessive anxiety and worry about a number of events or activities, such as work activities, school performance, or any other situations? ☐ Yes ☐ No ☐ Unknown

2. Has this anxiety or worry occurred on more days than not for at least the last 6 months? ☐ Yes ☐ No ☐ Unknown

If the questions 1 and 2 in A above were endorsed, proceed with remaining questions for this disorder; otherwise, skip to next disorder.

B. Does your child find it difficult to control his/her worry? ☐ Yes ☐ No ☐ Unknown

C. Generalized Anxiety Disorder Symptom List

Has your child's anxiety or worry been associated with any of the following behaviors for more days than not over the past 6 months?

	Yes	**No**	**Unknown**
1. Restlessness or feeling keyed up or on edge			
2. Being easily fatigued or tired			
3. Difficulty concentrating or mind going blank			
4.Irritability			
5. Muscle tension			
6. Sleep disturbance or difficulties falling asleep, staying asleep, or restless and unsatisfying sleep			

D. Have these worries created distress for your child or impairment in any of the following areas?

	Yes	No	Unknown
Social relations with others			
Academic performance			
Any other areas of functioning			

Dysthymic Disorder

I would like to learn about your child's mood for most of the time.

A. Does your child show depressed mood or irritability for most of the day, by either his/her own report or your own observations of your child? ☐ Yes ☐ No ☐ Unknown

Has this depressed mood occurred more days than not for at least the past 12 months?

☐ Yes ☐ No ☐ Unknown

If the two questions in A above were endorsed, proceed with remaining questions for this disorder; otherwise, skip to next disorder.

B. Does your child show any of the following difficulties while he/she is depressed:

	Yes	No	Unknown
1. Poor appetite or overeating			
2. Insomnia (trouble falling asleep) or hypersomnia (excessive sleeping)			
3. Low energy or fatigue			
4. Low self-esteem			
5. Poor concentration or difficulty making decisions			
6. Feelings of hopelessness			

C. During the 12 months or more that your child has shown this depressed mood, has he/she ever been without this depressed mood or the other difficulties you mentioned for at least 2 consecutive months?

☐ Yes ☐ No ☐ Unknown

D. Has this depressed mood created distress for your child or impairment in any of the following areas?

	Yes	No	Unknown
Social relations with others			
Academic performance			
Any other areas of functioning			

Major Depressive Disorder

A. Major Depressive Disorder Symptom List

Has your child developed any of the following for at least a 2-week period of time?

	Yes	No	Unknown
1. Depressed or irritable mood most of the day nearly every day for at least 2 weeks			
2. Markedly diminished interest or pleasure in all or almost all activities most of the day, nearly every day for at least 2 weeks			
3. Significant weight loss, when not dieting			
Significant weight gain.			
Decrease or increase in appetite nearly every day.			
Failed to meet expected weight gains			
4.Insomnia (trouble falling asleep) or hypersomnia (excessive sleep) nearly every day			
5. Agitated or excessive movement nearly every day			
Lethargic, sluggish, slow moving, or significantly reduced movement or activity nearly every day			
6. Fatigue or loss of energy nearly every day			
7. Feelings of worthlessness or excessive or inappropriate quilt nearly every day			
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day			
9. Recurrent thoughts of death			
Recurrent thoughts of suicide without a specific plan			
Suicide attempt or a specific plan for committing suicide			

If five or more of symptoms 1-9 were endorsed, proceed. If not, skip to the next disorder.]

B. Have these symptoms of depression created distress for your child in any of the following areas?

	Yes	No	Unknown
Social relations with others			
Academic performance			
Any other areas of functioning			

Bipolar I Disorder: Manic Episode

A. Has your child ever experienced a period of time that lasted at least 1 week;

	Yes	No	Unknown
1. Where his/her mood was unusually and persistently elevated; that is, he/she felt abnormally happy, giddy, joyous, or ecstatic well beyond normal feelings of happiness?			
2. Or where his/her mood was abnormally and persistently expansive; that is, your child felt able to accomplish everything he/she decided to do, felt nearly superhuman in his/her ability to do anything he/she wished to do, or felt as if his/her abilities were without limits?			

	Yes	No	Unknown
3. Or where his/her mood was abnormally and persistently irritable; that is, he/she was unusually touchy, too easily prone to anger or temper outbursts, too easily annoyed by events or by others, or abnormally cranky?			

If any of the above three were endorsed, proceed with B; otherwise, skip to next disorder.

B. During the week or more that your child showed this abnormal and persistent mood, did you notice any of the following to be persistent and/or occurring to an abnormal or significant degree?

	Yes	No	Unknown
1. Had inflated self-esteem or felt grandiose about self well beyond what would be characteristic for his/her level of abilities			
2. Showed a decreased need for sleep; for instance, he/she stated that he/she felt rested after only 3 hours of sleep			
3. Was more talkative than usual or seemed to feel pressured to keep talking			
4.Skipped from one idea to another and then another in speech as if his/her ideas were flying rapidly by			
Stated that he/she felt that his/her thoughts were racing or flying by at an abnormal rate of speed			
5. Was distractible; that is, his/her attention was too easily drawn to unimportant or irrelevant events or things around him/her			
6. Showed an increase in goal-directed activity; that is, he/she become unusually and persistently productive or directed more activity than normal toward the tasks he/she wanted to accomplish			
Seemed very agitated, overly active, or abnormally restless			
7. Showed an excessive involvement in pleasurable activities that have a high likelihood of negative, harmful, or painful consequences			

If three or more symptoms above were endorsed, proceed with remaining criteria; otherwise, skip to next disorder.

C. General

	Yes	No	Unknown
1. Was this disturbance in your child's mood enough to cause severe impairment, disruption, or difficulties with social relationships, academic performance, or other important activities			
2. Or, did your child's abnormal mood lead to him/her being hospitalized to prevent harm to him/herself or others			
3. Or, did your child have hallucinations (explain) or bizarre ideas (psychotic thinking), or feel or act paranoid (as if others were intentionally out to harm him/her)			

Other Mental and Developmental Disorders

1. Does this child have any things about which he/she seems obsessed or can he/she not get his/her mind off of a particular topic? ☐ Yes ☐ No ☐ Unknown

2. Does this child have any unusual behaviors he/she must perform, such as dressing, bathing, mealtime, or counting rituals? ☐ Yes ☐ No ☐ Unknown

3. Does this child demonstrate any nervous tics or other repetitive, abrupt nervous movements or vocal noises? ☐ Yes ☐ No ☐ Unknown

4.Has this child made comments or acted in such a way that he/she seemed to see things, hear things, or feel things on his/her skin that really did not exist (hallucinations)? ☐ Yes ☐ No ☐ Unknown

5. Has this child ever reported bizarre or very strange or peculiar ideas that seemed very unusual compared to other children (delusions)? ☐ Yes ☐ No ☐ Unknown

PARENT MANAGEMENT METHODS

Now let's move on and talk about how you have tried to manage your child's behavior, especially when it was a problem for you. When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?

If these methods do not work and the problem behavior continues, what are you likely to do then to cope with your child's misbehavior?

CHILD'S EVALUATION AND TREATMENT HISTORY

Has your child ever been evaluated previously for developmental, behavioral, or learning problems?

☐ Yes ☐ No ☐ Unknown

If so, who provided the evaluation, what type of evaluation did the child have, and what were you told about your child regarding the results of any evaluations?

Has your child ever received any psychiatric or psychological treatment?

☐ Yes ☐ No ☐ Unknown

If so, what type of treatment did he/she receive and how long did the treatment last?

Who provided this treatment to your child? _____

Has your child ever received any medication for his/her behavior or emotional problems?

☐ Yes ☐ No ☐ Unknown

If so, what type of medication did he/she take, at what dose, and for how long?

SCHOOL HISTORY

For each grade the child has been in, beginning with preschool, list which school the child attended and whether the child had any behavioral or learning problems that year, and if so, briefly note their nature below.

Has this child ever received any special education services? ☐ Yes ☐ No ☐ Unknown

If so, what types of services did he/she receive and in what grades?

CHILD'S PSYCHOLOGICAL AND SOCIAL STRENGTHS

I realize I have asked you a lot about any problems your child might be having, But it is also important that I know about your child's psychological and social strong points. Please tell me about any abilities your child seems to have or any activities at which he/she is particularly good. For instance, what hobbles and sports does your child enjoy and do well at, what are his/her best subjects in school, what sorts of games or social activities does he/she do well in? In other words, tell me what you consider to be your child's strongest or best points.

FAMILY HISTORY

Let's review the family history of any psychiatric and/or learning problems, using the following three sections. The first is for mom's side of the family, the second for dad's side, and the third for the siblings of the child being evaluated. It is important in understanding a child's behavioral problems to know whether other biological relatives of the child have had psychological, emotional, or developmental problems. Many such disorders run in families and may contribute genetically to the child's problems. Start with the maternal side of the family and review each of the mother's relatives, noting whether they have any of the disorders listed on the left side of the form. If so, place an X under the column representing that relative. Then do the same for the paternal relatives and the child's siblings.]

Child's Mother and Maternal Relatives	**Child's Mother**	**Child's maternl Grand-mother**	**Child's maternl Grand-father**	**Child's maternl uncle**	**Child's maternl uncle**	**Child's maternl aunt**	**Child's maternl aunt**	**Other: _____**
Problems with aggressiveness, defiance, and oppositional behavior as a child								
Problems with attention, activity, and impulse control as a child								
Learning disabilities								
Failed to graduate from high school								
Mental retardation								
Psychosis or schizophrenia								
Depression for more than 2 weeks								
Anxiety disorder that impaired adjustment								
Tics or Tourette's								
Alcohol abuse Substance abuse								
Antisocial behavior (assaults, thefts, etc.)								
Arrests								
Physical abuse								
Sexual abuse								

Child's Father and Paternal Relatives	**Child's Father**	**Child's paternal Grand-mother**	**Child's paternal Grand-father**	**Child's paternal uncle**	**Child's paternal uncle**	**Child's paternal aunt**	**Child's paternal aunt**	**Other: ____**
Problems with aggressiveness, defiance, and oppositional behavior as a child								
Problems with attention, activity, and impulse control as a child								
Learning disabilities								
Failed to graduate from high school								
Mental retardation								
Psychosis or schizophrenia								
Depression for more than 2 weeks								
Anxiety disorder that impaired adjustment								
Tics or Tourette's								
Alcohol abuse Substance abuse								
Antisocial behavior (assaults, thefts, etc.)								
Arrests								
Physical abuse								
Sexual abuse								

This Child's Siblings

Indicate the siblings and birth order for the client (your child):	**1st born brother, sister or the client**	**2nd born brother, sister or the client**	**3rd born brother, sister or the client**	**4th born brother, sister or the client**	**5th born brother, sister or the client**
Problems with aggressiveness, defiance, and oppositional behavior as a child					
Problems with attention, activity, and impulse control as a child					
Learning disabilities					
Failed to graduate from high school					
Mental retardation					
Psychosis or schizophrenia					
Depression for more than 2 weeks					
Anxiety disorder that impaired adjustment					
Tics or Tourette's					
Alcohol abuse Substance abuse					
Antisocial behavior (assaults, thefts, etc.)					
Arrests					
Physical abuse					
Sexual abuse					