BOSTON CHILDREN'S HOSPITAL
DEPARTMENT OF PSYCHIATRY

CHILD & FAMILY HISTORY QUESTIONNAIRE

This questionnaire will give us important information that will help us understand your child and plan how to be most helpful to him or her. Please fill it out completely. If there are parts you don't understand, your clinician can help you at your first appointment. Thank you!

What is today's date?

What is the child's name?

What is the child's birthdate?

What is the child's sex?

What is your name?

What is your relationship to the child?

☐ Biological Mother ☐ Biological Father ☐ Adoptive Mother ☐ Adoptive Father ☐ Foster Mother ☐ Foster Father

If other, please specify:

Are you the child's legal guardian? Yes ☐ No ☐

If no, who is the child's legal guardian?

If the Department of Children and Families (DCF) is the legal guardian, please provide the following:

Caseworker Name: Telephone:

CURRENT DIFFICULTIES

Please describe your child's difficulties that led you to request our services:

STRESSFUL EVENTS

Which of the following events has EVER happened to the child?

☐ Child's primary caregiver died

☐ Child experienced a long separation from his/her/their primary caregiver

☐ Child was exposed to domestic or community violence

- [ ] Child has been physically or sexually abused
- [ ] Child has been bullied or rejected by schoolmates
- [ ] Child has been in foster care
- [ ] Child has had court (judge or lawyer) involvement
- [ ] Child has witnessed frequent arguing between his/her/their parents or family members
- [ ] Child's parents have separated or divorced
- [ ] Child has been involved in custody or visitation disagreements
- [ ] Child's immediate family has had a change in its members
- [ ] Child's immediate family has had major financial difficulties
- [ ] Child's immediate family has had struggles with having enough food at home
- [ ] Child's immediate family has changed housing multiple times
- [ ] Child's immediate family member has had a serious medical problem
- [ ] Child's immediate family member has had mental illness
- [ ] Child's immediate family member has had substance abuse problems
- [ ] Child's immediate family member has been incarcerated
- [ ] Child has had a serious injury or illness
- [ ] Child has changed schools multiple times
- [ ] Child is stressed about his/her/their school performance
- [ ] Other (specify):
- [ ] None of the above

CURRENT BEHAVIORAL HEALTH TREATMENT

Which of the following behavioral health services is the child receiving NOW?

- [ ] **No current services**

☐ **Psychiatric Medication**

Name of clinic:

Name of prescriber: Phone:

Name of Medication	Dose	Reason for Taking Medication	For How Long Has This Medication Been Taken?

☐ **Therapy**

Name of agency:

Name of clinician: Phone:

How often does child see the therapist?

For how long has the child been working with this therapist?

☐ **Other Services (specify):**

PAST BEHAVIORAL HEALTH TREATMENT

Which of the following behavioral health services has the child received in the PAST?

☐ **No past services**

☐ **Hospitalization on a psychiatric inpatient unit**

When	Name of Hospital	For What Kind of Problem

☐ **Day Treatment Program (partial hospitalization)**

When	Name of Program	For What Kind of Problem

☐ **Psychiatric Medication**

Name of Medication	Dose	Reason for Taking Medication	For How Long Was This Medication Taken?	Reason for Stopping (if no longer taking)

☐ **Therapy**

Name of Therapist	Agency	Reason for Therapy	How Long Did Therapy Last?	Reason for Stopping (if no longer participating)

☐ **Other Services (specify)**:

Has the child ever been evaluated for a behavioral health problem in a hospital emergency room or by a mobile crisis team?

☐ No ☐ Yes If Yes, when?

Which of the following agencies has the child been involved with?

☐ Department of Children and Families
☐ Department of Mental Health
☐ Department of Youth Services
☐ Department of Developmental Services
☐ None of the above

MEDICAL

Which of the following medical problems has the child had, either NOW or in the PAST?

☐ Anemia
☐ Asthma
☐ Stomach or intestine problems (celiac, colitis)
☐ Heart problems (chest pain, pounding heart, murmur)
☐ Head injury
☐ Diabetes
☐ Headaches
☐ Trouble hearing
☐ Liver problems (hepatitis)
☐ Blood cholesterol problems
☐ Thyroid problems
☐ Brain infection (meningitis, encephalitis)
☐ Overweight
☐ Seizures
☐ Sexually transmitted diseases
☐ Dizzy/fainting spells
☐ Trouble seeing
☐ Kidney problems
☐ Allergies (specify):

☐ Other (specify):

☐ No medical problems

Does the child take medication for medical problems? ☐ Yes ☐ No

If yes, please specify:

When was the child's last complete physical exam?

To your knowledge, what were the results of the physical?

☐ Normal ☐ Abnormal (describe):

Has the child been hospitalized for an illness, injury, or surgery? ☐ Yes ☐ No
If yes, please specify below:

WHEN	FOR WHAT KIND OF PROBLEM

BIRTH AND EARLY DEVELOPMENT

Which of the following problems did the child's birth mother have during her pregnancy with the child?

☐ Excessive vomiting

☐ Seizures

☐ High or low blood sugar

☐ Bleeding

☐ Injury to the abdomen

☐ Victim of violence

☐ Use of alcohol

☐ Use of street drugs (specify which):

☐ Use of medicine prescribed by a doctor (specify which):

☐ Anemia

☐ High blood pressure (toxemia)

☐ Infection

☐ X-rays to the abdomen

☐ Stress or depression

☐ Use of cigarettes

☐ No pregnancy problems

☐ I don't know

Which of the following problems did the child's birth mother or the child have <u>during or after the child's birth</u>?

☐ Premature delivery

☐ Low birthweight

☐ Breech or forceps delivery

☐ C-section

☐ Infection in mother or child at delivery

☐ Yellow jaundice

☐ "Blue baby" (lack of oxygen at birth)

☐ Birth injury or defects in child

☐ Postpartum depression in the mother

☐ Hospital intensive care for the child

☐ Other (specify):

☐ No labor/delivery problems

☐ I don't know

When did the child reach each of the developmental milestones?

Crawled	☐ Usual	☐ Late	☐ I don't know
Walked	☐ Usual	☐ Late	☐ I don't know
Spoke words	☐ Usual	☐ Late	☐ I don't know
Spoke sentences	☐ Usual	☐ Late	☐ I don't know
Was toilet trained	☐ Usual	☐ Late	☐ I don't know

1. **Please select how often the child had the following difficulties <u>when he/she/they was an infant or</u> <u>toddler</u>**

Slow to warm up to people: Hardly Ever

Cried or was cranky or irritable: Hardly Ever

Strong feelings when upset: Hardly Ever

Trouble adapting to changes: Hardly Ever

Stubborn: Hardly Ever

Avoided new things, people, or experiences: Hardly Ever

Irregular or difficult eating or sleeping: Hardly Ever

Very active: Hardly Ever

Difficulty staying focused when playing: Hardly Ever

SCHOOL

What grade is the child in this year? ☐ Ungraded classroom

What kind of placement does the child have this year?

☐ Regular education ☐ 504 Plan ☐ Special education (has an IEP)

If the placement is special education, what is the child's disability?

☐ Learning ☐ Emotional/Behavioral ☐ Autism ☐ Speech/Language

☐ Other:

What are the child's usual grades?

☐ Mostly A's or B's (4's) ☐ Mostly C's (3's) ☐ Mostly D's (2's) ☐ Mostly F's (1's)

Has the child ever repeated a grade? ☐ Yes ☐ No If Yes, which grade(s)?

Has the child ever been suspended or expelled? ☐ Yes ☐ No

If Yes, which grade(s) and what for?

Are there language or cultural issues that affect the child's school performance?

☐ Yes ☐ No If Yes, please describe:

What special interests does the child enjoy?

☐ Arts (music, dance, art, acting) ☐ Sports ☐ Technical (computer, robotics)

☐ Literary (reading, writing) ☐ Other (specify):

How well does the child do with each of the following?

Attendance: ☐ good ☐ average ☐ poor

Schoolwork: ☐ good ☐ average ☐ poor

Homework: ☐ good ☐ average ☐ poor

Classroom behavior: ☐ good ☐ average ☐ poor

Friendships: ☐ good ☐ average ☐ poor

Enjoyment of school: ☐ good ☐ average ☐ poor

COMMUNITY ACTIVITIES

Which of the following community activities does the child regularly participate in?

☐ Summer Camp

☐ Afterschool Program

☐ Sports League

☐ Church, Temple or Mosque Activities

☐ Music, Art, or Dance Lessons

☐ Volunteer Activities

☐ Part-time Employment

☐ Other (specify):

NUTRITION & HEALTH

Do you feel that the child has a healthy diet?

☐ Yes ☐ No If No, Why not?

What time does the child fall asleep on school nights?

What time does the child wake up on school days?

On a typical day, how many hours does the child use video or computer games?

EXERCISE

In a typical week, how many times does the child engage in physical activity for at least 30 minutes?

☐ 1-2 times ☐ 3-4 times ☐ 5-6 times ☐ Every day

What are the child's usual types of exercise?

SOCIAL HISTORY

What is the current marital status of the child's parents?

☐ Married ☐ Separated or divorced
☐ Partnered ☐ Never married
☐ Widowed

What is the child's current living situation?

☐ Living with parent(s)/guardian(s)
☐ Foster Care
☐ Department of Youth Services
☐ Other
☐ Living with other family member(s)
☐ Residential/group home
☐ Shelter

If Other, please specify:

Please list all of the adults and children that live with the child right now:

Name	Age	Gender	Relationship to Child

What languages are spoken in the child's home?

Which cultural group(s) does the child's family identify with?

Which religion does the child's family practice (if any)?

Please rate the child's relationships with each of the following:

Parents: ☐ Close ☐ Distant ☐ Difficult

Siblings: ☐ Close ☐ Distant ☐ Difficult

Peers: ☐ Close ☐ Distant ☐ Difficult

CURRENT PARENTS

Mother (or 1st Parent):

How much schooling did Mother (or 1st Parent) finish?

☐ Less than 8th grade ☐ 8th grade ☐ High School ☐ GED ☐ College ☐ Post-Graduate

What is Mother's (or 1st Parent's) occupation?

☐ Full-time ☐ Part-time ☐ Currently unemployed

Father (or 2nd Parent):

How much schooling did Father (or 2nd Parent) finish?

☐ Less than 8th grade ☐ 8th grade ☐ High School ☐ GED ☐ College ☐ Post-Graduate

What is Father's (or 2nd Parent's) occupation?

☐ Full-time ☐ Part-time ☐ Currently unemployed

BIOLOGICAL PARENTS (***if different from current parents***)

Mother:

How much schooling did Mother finish?

☐ Less than 8th grade ☐ 8th grade ☐ High School ☐ GED ☐ College ☐ Post-Graduate

What is Mother's occupation?

☐ Full-time ☐ Part-time ☐ Currently unemployed

Father:

How much schooling did Father finish?

☐ Less than 8th grade ☐ 8th grade ☐ High School ☐ GED ☐ College ☐ Post-Graduate

What is Father's occupation?

☐ Full-time ☐ Part-time ☐ Currently unemployed

FAMILY HEALTH HISTORY

Which of the following health problems have the child's blood relatives suffered from?

Health problems	**Mother**	**Father**	**Brother**	**Sister**	**Other**
Attention-Deficit/Hyperactivity	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐
Bipolar	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Developmental delay	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Drug or alcohol abuse	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐
High blood cholesterol	☐	☐	☐	☐	☐
Intellectual disability	☐	☐	☐	☐	☐

Health problems (continued)	**Mother**	**Father**	**Brother**	**Sister**	**Other**
Learning disability	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐
Obsessions/compulsive behavior	☐	☐	☐	☐	☐
Posttraumatic stress disorder	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Suicide death	☐	☐	☐	☐	☐
Sudden death from heart attack before age 50	☐	☐	☐	☐	☐
Tics/Tourette's	☐	☐	☐	☐	☐
None of the above	☐	☐	☐	☐	☐

CHILD SYMPTOM MEASURE - PARENT/GUARDIAN REPORT*

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, check the box next to the number that best describes how much (or how often) your child has been bothered by each problem during the past TWO (2) WEEKS.

DO NOT COMPLETE THIS SECTION IF YOUR CHILD IS LESS THAN 6 YEARS OLD.

	During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Complained of stomachaches, headaches, or other aches and pains?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	2. Said he/she/they was worried about his/her/their health or about getting sick?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
II.	3. Had problems sleeping – that is, trouble falling asleep, staying asleep, or waking up too early?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
III.	4. Had problems paying attention when he/she/they was in class or doing his/her/their homework or reading a book or playing a game?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
IV.	5. Had less fun doing things than he/she/they used to?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	6. Seemed sad or depressed for several hours?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
V. & VI.	7. Seemed more irritated or easily annoyed than usual?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	8. Seemed angry or lost his/her/their temper?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VII.	9. Started lots more projects than usual or did more risky things than usual?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	10. Slept less than usual for him/her/them, but still had lots of energy?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VIII.	11. Said he/she/they felt nervous, anxious, or scared?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	12. Not been able to stop worrying?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	13. Said he/she/they couldn't do things he/she/they wanted to or should have done, because they made him/her/them feel nervous?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
IX.	14.	Said he/she/they heard voices – when there was no one there – speaking about him/her/them or telling him/her/them what to do or saying bad things to him/her/them?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	15.	Said that he/she/they has a vision when he/she/they was completely awake – that is, saw something or someone that no one else could see?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
X.	16.	Said that he/she/they had thoughts that kept coming into his/her/their mind that he/she/they would do something bad or that something bad would happen to him/her/them or to someone else?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	17.	Said he/she/they felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	18.	Seemed to worry a lot about things he/she/they touched being dirty or having germs or being poisoned?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	19.	Said that he/she/they had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
		In the past **TWO (2) WEEKS,** has your child…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, used snuff/chewing tobacco, or vaped nicotine?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy or molly), hallucinogens (like LSD or shrooms), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			

In the past **TWO (2) WEEKS,** has your child…					
23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know	

*Adapted from DSM-5 Parent/Guardian Level 1 Cross-Cutting Measure - Child Age 6-17
(Questions #24 and #25 assessed in diagnostic visit)

THANK YOU FOR TAKING THE TIME TO PROVIDE US WITH THIS IMPORTANT INFORMATION