Kansas City Psychiatric Group

(4/27/15)

PARENT QUESTIONNAIRE
(For Child and Adolescent Patients)

Filled out by_____ **Date Completed**_____
(Name & Relationship)

Child's Full Name_____ **School**_____

Birthdate_____ **Age**_____ **Grade**_____ **Teacher** _____

Sex _____**Height**_____**Weight**_____ **Physician**_____

Adopted Child: ___Yes ___No At what age: _____ **Referred by**_____

Mother's Name: _____

Father's Name: _____

PRESENTING PROBLEMS:
What is your child's difficulty and for how long? _____
_____
_____
_____
_____

PLEASE CIRCLE ANY OF THE FOLLOWING PROBLEMS WHICH PERTAIN TO YOUR CHILD:

Aggression	Fatigue	Learning Problems	Self Injury
Alcohol Use	Fire Setting	Loneliness	Sexual Behavior
Anxiety	Food Restriction	Low Interest in Activities	Sleep Problems
Appetite Changes	Guilt	Mood Swings	Speech Problems
Bed Wetting	Headaches	Nervousness	Soiling Pants/Bed
Binge Eating	Head Injuries	Nightmares	Stomachaches
Colic	Hearing Voices	Obsessive Thoughts	Stress
Concentration Problems	High Temperatures	Panic Attacks	Suicidal Thoughts
Confusion	Homicidal Thoughts	Paranoia	Temper Tantrums
Coordination Problems	Hopelessness	Poor Memory	Tiredness
Depression	Hyperactivity	Purging	Unhappiness
Dizziness	Inability to Sleep	Racing Thoughts	Vivid Dreams
Drug Use	Inattention	Restlessness	Weight Gain
Eating Problems	Involuntary Movement	Runaway	Weight Loss
Excessive Sleep	Irritability	Seeing Visions	Wetting Pants/Bed
Other Serious Injuries*	Hospitalizations*	Seizures	

***Explanation:**_____

MEDICAL AND PSYCHIATRIC HISTORY:
Has your child ever received psychological help or counseling of any kind before? _____Yes _____No
If yes, please explain:_____
_____

Please list all psychiatric or therapeutic treatment on either an outpatient or inpatient basis. Use the back of this form for additional space.

Date	Hospital or Clinician	Reason

Describe any traumatic events: _____

_____

_____

Does your child have any medical problems? _____ yes _____ no

If yes, please explain: _____

_____

List ALL MEDICATIONS your child is <u>currently</u> taking: _____

_____

_____

_____

List all psychiatric medications your child has taken in the PAST (e.g. antidepressant, anxiety medication, sleeping pills, etc.):

_____

_____

_____

Is your child allergic to any medication or have other allergies? _____

_____

_____

Have report cards or school conferences indicated any special difficulty? ____Class work ____Behavior ____Attitude

Explain: _____

Any Special Education Evaluations or services? ____ yes ____ no

Date(s) of Assessment _____

Learning Disability _____

Program _____

Other professional agency contacts:

_____Regional Diagnostic Clinic **_____Family and Children's Services (DFS, SRS)**

_____Juvenile Court **_____Other** _____

Explain: _____

<u>FAMILY HISTORY:</u>

Does your child have any relatives with known or suspected psychiatric or emotional difficulties (i.e. depression, anxiety, alcohol or drug abuse, schizophrenia, learning disabilities, hyperactivity, etc?)

<u>Mother</u> _____

<u>Father</u> _____

<u>Siblings</u> _____

<u>Other</u> _____

DRUG AND ALCOHOL HISTORY:

List below all forms of alcohol, drugs and prescription drugs which your child has ever used or abused. Use the back of this form for additional space.

Type (please circle)	Amount	First Use	Last Use
Alcohol			
Marijuana			
Cocaine			
Methamphetamine			
LSD/Opiates/Heroin/IV Drugs			
Other:			
Caffeine (coffee, soda, etc.)			
Nicotine (cigarettes, etc.) (packs per day)			

Has he/she ever received treatment for drug and/or alcohol abuse problems? ____yes ____no

If yes, describe:_____

LIVING SITUATION:

Please list *Adults* in the home:

	Name	Age	Sex	Relationship To Patient	Education (years)	Occupation	Employer
1.							
2.							
3.							

Please list *Other Children* in the home:

	Name	Age	Sex	Relationship to Pt	School	Grade
4.						
5.						
6.						
7.						

Marital status of natural parents of child (check all appropriate spaces):

___Married	___Living together	___Mother remarried
___Not Married	___Separated	___Father remarried
___One parent deceased	___Divorced	___Other_____

DEVELOPMENTAL HISTORY:

Mother's health during pregnancy: ____good ____problematic (describe below)

_____

_____

Delivery: _____full term _____early _____late

Length of labor: _____hours Forceps used: ____ yes ____ no Birth Weight_____

Any problems or complications during or after delivery?_____

Was there any delay in achievement of developmental milestones? _____ yes _____no

If so, describe: _____

_____

Other information:

_____

_____

_____

_____