

PATIENT BACKGROUND QUESTIONNAIRE

Child's Name: _____ Today's Date: _____

Birth Date: _____ Age: _____ Sex: Male Female

Address: _____

Home phone: _____ Cell phone (M) _____ (D) _____

Person completing this form: Mother Father Stepmother Stepfather Guardian Self

Mother's Name: _____ Email address: _____

Father's Name: _____ Email address: _____

Stepparent's Name: _____ Email address: _____

Marital Status of Parents: Married Separated Divorced Widowed

If separated or divorced, how old was the child when the separation occurred? _____

Primary language spoken in the home: _____ Other languages spoken in the home: _____

Was the child adopted? Yes No If yes, at what age? _____ Does the child know? Yes No

PRESENTING PROBLEM

Briefly describe your child's current difficulties: _____

How long has this problem been of concern to you? _____

When was the problem first noticed? _____

What seems to help the problem? _____

What seems to make the problem worse? _____

Have you noticed changes in the child's abilities? Yes No

If yes, please describe: _____

Have you noticed changes in the child's behaviour? Yes No

If yes, please describe: _____

Has the child been evaluated or treated for the current problem or similar problems? Yes No

If yes, when and with whom? _____

Is the child being treated for a medical illness? Yes No

If yes, for what condition is the child being treated? _____

Is the child on any medication at this time? Yes No

If yes, please note the kind of medication: _____

Has the child previously received counselling? Yes No

If yes, when and with whom? _____

Has the child previously undergone a formal psychological assessment? Yes No

If yes, when and were there any diagnoses? _____

What specific questions would you like answered by this assessment? _____

BEHAVIORAL/EMOTIONAL CONCERNS

Place a check next to any behavior or problem that your child currently exhibits.

Inattention:

- Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
- Often has difficulty sustaining attention to tasks or play activities
- Often does not seem to listen when spoken to directly
- Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behaviour or failure to understand instructions)
- Often has difficulty organizing tasks and activities
- Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
- Is often easily distracted by extraneous stimuli
- Is often forgetful in daily activities

How long have these been of concern to you? _____

Impulsivity:

- Often blurts out answers before questions have been completed
- Often has difficulty awaiting turn
- Often interrupts or intrudes on others (e.g., butts into conversations or games)

How long have these been of concern to you? _____

Hyperactivity:

- Often fidgets with hands or feet or squirms in seat
- Often leaves seat in classroom or in other situations in which remaining seated is expected
- Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- Often has difficulty playing or engaging in leisure activities quietly
- Is often “on the go” or often acts as if “driven by a motor”
- Often talks excessively

How long have these been of concern to you? _____

Oppositional Behaviours:

- | | |
|--|--|
| <input type="checkbox"/> Often loses temper | <input type="checkbox"/> Often argues with adults |
| <input type="checkbox"/> Often actively defies or refuses to comply with adults’ requests or rules | <input type="checkbox"/> Often deliberately annoys people |
| <input type="checkbox"/> Often blames others for his or her mistakes or misbehaviour | <input type="checkbox"/> Is often touchy or easily annoyed by others |
| <input type="checkbox"/> Is often angry or resentful | <input type="checkbox"/> Is often spiteful or vindictive |

How long have these been of concern to you? _____

Inappropriate Conduct:

- | | |
|---|--|
| <input type="checkbox"/> Often bullies, threatens, or intimidates others | <input type="checkbox"/> Often initiates physical fights |
| <input type="checkbox"/> Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, knife, gun) | <input type="checkbox"/> Has been physically cruel to people |
| <input type="checkbox"/> Has stolen while confronting a victim (e.g., mugging, purse snatching, armed robbery) | <input type="checkbox"/> Has been physically cruel to animals |
| <input type="checkbox"/> Has deliberately engaged in fire setting with the intention of causing serious damage | <input type="checkbox"/> Has forced someone into sexual activity |
| <input type="checkbox"/> Has broken into someone else’s house, building, or car | <input type="checkbox"/> Has deliberately destroyed others’ property (other than by fire setting) |
| <input type="checkbox"/> Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking & entering, forgery) | <input type="checkbox"/> Often lies to obtain goods or favours or to avoid obligations (i.e., “cons” others) |
| <input type="checkbox"/> Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for lengthy a period) | <input type="checkbox"/> Often stays out at night despite parental prohibitions, beginning before age 13 years |
| | <input type="checkbox"/> Is often truant from school, beginning before age 13 |

How long have these been of concern to you? _____

Depression:

- depressed mood most of the day, nearly every day, as indicated by either subjective reports (e.g., feel sad or empty) or observations made by others (e.g., appears tearful). **Note:** in children and adolescents, can be irritable mood
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observations made by others)
- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains
- Difficulty falling asleep or waking up
- Physical restlessness (observable by others, not merely subjective feelings of restlessness or being slowed down)
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
- Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or suicide attempt or a specific plan for committing suicide

How long have these been of concern to you? _____

Anxiety:

- Excessive worrying or anxiety (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as school performance)
- Finds it difficult to control the worry
- Feelings of restlessness or being on edge
- Being easily fatigued
- Difficulty concentrating or mind going blank
- Irritability or anger
- Muscle tension
- Sleep disturbances (difficulty falling or staying asleep, or restless unsatisfying sleep)

How long have these been of concern to you? _____

ACADEMIC CONCERNS

At what age did your child begin kindergarten? _____ What is his or her current grade? _____

Is your child in a special education class? Yes No

If yes, what type of class? _____

Has your child been held back a grade? Yes No

If yes, what grade and why? _____

Has your child ever received special tutoring or therapy at school? Yes No

If yes, please describe: _____

Has your child's school performance become poorer recently? Yes No

If yes, please describe: _____

Has your child missed a lot of school? Yes No

If yes, please indicate reasons: _____

DEVELOPMENTAL HISTORY

Were there any problems during the pregnancy? Yes No

If yes, what kind? _____

Was this a first pregnancy? Yes No

If no, how many times was the mother previously pregnant? _____

During pregnancy, did the mother drink alcoholic beverages? Yes No

If yes, what did she drink? _____

Approximately how much alcohol was consumed each day? _____

When was the alcohol consumed? 1st trimester 2nd trimester 3rd trimester

Were there times when five or more drinks were consumed at one time during pregnancy? Yes No

If yes, during which trimester? 1st trimester 2nd trimester 3rd trimester

During pregnancy, did the mother use drugs (including prescription, over-the-counter, and recreational)?

Yes No

If yes, what kind? _____

During pregnancy, was the mother exposed to any x-rays or chemicals? Yes No

If yes, what kind? _____

Were there any complications associated with the delivery? Yes No

If yes, what kind? _____

Was the child premature? Yes No If yes, by how many weeks? _____

What was the child's birth weight? _____

Were there any birth defects or complications? Yes No

If yes, please describe: _____

Were there any other problems? Yes No

If yes, please describe: _____

CHECKLIST FOR SOCIAL & EMOTIONAL CONCERNS

Place a check next to any behaviour or difficulty that your child currently exhibits.

- | | |
|--|--|
| <input type="checkbox"/> Has difficulty making friends | <input type="checkbox"/> Shows sexually provocative or inappropriate behaviour |
| <input type="checkbox"/> Has difficulty keeping friends | <input type="checkbox"/> Is slow to learn |
| <input type="checkbox"/> Does not get along with other children | <input type="checkbox"/> Has difficulty accepting criticism |
| <input type="checkbox"/> Fights with other children | <input type="checkbox"/> Has difficulty with coordination |
| <input type="checkbox"/> Is more interested in things (objects) than in people | <input type="checkbox"/> Has unusual motor tics |
| <input type="checkbox"/> Prefers to be alone | <input type="checkbox"/> Has unusual vocal tics |
| <input type="checkbox"/> Does not get along well with siblings | <input type="checkbox"/> Bites nails |
| <input type="checkbox"/> Refuses to share | <input type="checkbox"/> Sucks thumb |
| <input type="checkbox"/> Does not understand other people's feelings | <input type="checkbox"/> Is jealous |
| <input type="checkbox"/> Constantly seeks attention | <input type="checkbox"/> Is shy and/or timid |
| <input type="checkbox"/> Requires constant supervision | <input type="checkbox"/> Is aggressive |
| <input type="checkbox"/> Lies | <input type="checkbox"/> Is argumentative |
| <input type="checkbox"/> Steals | <input type="checkbox"/> Has too many accidents |
| <input type="checkbox"/> Is disobedient | <input type="checkbox"/> Injures self intentionally |
| <input type="checkbox"/> Eats poorly | <input type="checkbox"/> Shows anger easily |
| <input type="checkbox"/> Is clumsy | <input type="checkbox"/> Engaged in dangerous behaviour |
| <input type="checkbox"/> Is nervous | If yes, describe: _____ |
| <input type="checkbox"/> Is immature | <input type="checkbox"/> Has unusual fears, habits, or mannerisms |
| <input type="checkbox"/> Is easily frustrated | If yes, describe: _____ |
| <input type="checkbox"/> Worries excessively | <input type="checkbox"/> Rocks back and forth |
| <input type="checkbox"/> Feels that he or she is bad | <input type="checkbox"/> Has trouble sleeping |
| <input type="checkbox"/> Does not show feelings | <input type="checkbox"/> Has frequent nightmares |
| <input type="checkbox"/> Gets hurt frequently | <input type="checkbox"/> Wets the bed |
| <input type="checkbox"/> Does not learn from experience | <input type="checkbox"/> Tires easily and has little energy |
| | <input type="checkbox"/> Complains of aches and pains |

CHILD'S MEDICAL HISTORY

Place a check next to any illness or condition that your child has had. When you check an item, please note the approximate age of the child when he or she had the illness or condition and any other pertinent information.

Illness or Condition	Age	Explain
<input type="checkbox"/> Encephalitis	_____	_____
<input type="checkbox"/> Meningitis	_____	_____
<input type="checkbox"/> Diabetes	_____	_____
<input type="checkbox"/> Fainting Spells	_____	_____
<input type="checkbox"/> Memory Problems	_____	_____
<input type="checkbox"/> Eye Problems	_____	_____
<input type="checkbox"/> Ear Problems	_____	_____
<input type="checkbox"/> Suicide Attempt(s)	_____	_____
<input type="checkbox"/> Sleeping Problems	_____	_____
<input type="checkbox"/> Extreme Tiredness	_____	_____
<input type="checkbox"/> Frequent Headaches	_____	_____
<input type="checkbox"/> Convulsions	_____	_____
<input type="checkbox"/> Epilepsy	_____	_____
<input type="checkbox"/> Asthma	_____	_____

Has your child had any other serious illnesses? Yes No
If yes, what illness? _____

Has your child been hospitalized? Yes No
If yes, please describe: _____

Has your child had any operations? Yes No
If yes, please describe: _____

Has your child had any accidents? Yes No
If yes, please describe: _____

Has your child had a head injury? Yes No
If yes, please describe: _____

Has your child ever lost consciousness? Yes No
If yes, please describe: _____

Has your child experienced any emotional trauma? Yes No
If yes, please describe: _____

Additional Comments:

