CHILD & FAMILY QUESTIONNAIRE

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

PERSONAL INFORMATION

What is today's date?

What is the child's name?

What is the child's birthdate?

What is the child's gender? What are their preferred pronouns?

What is your name?

What is your relationship to the child?

◯ Biological Parent/Guardian ◯ Adoptive Parent/Guardian ◯ Foster Parent/Guardian

◯ Other—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: Phone #:

CURRENT DIFFICULTIES

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

What type of therapy/services are you looking for?

- ◯ Medication only
- ◯ Therapy only
- ◯ Medication & Therapy
- ◯ I don't know

CURRENT BEHAVIORAL HEALTH SERVICES

Which of the following behavioral health services is the child **currently** receiving?

- ◯ No current services
- ◯ Current psychiatric medication(s):

  Name of clinic:

  Who is prescribing psychiatric medication(s)?
- ◯ Therapy

  Name of agency (if applicable):

  Name of clinician: Phone #:

  How often does the child see the therapist?

  How long has the child been seeing this therapist?
- ◯ Other services (please specify):

PAST BEHAVIORAL HEALTH SERVICES

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

- ◯ No past services
- ◯ Hospitalization on an inpatient psychiatric unit

When	Name of hospital	For what kind of problem

Day treatment program (partial hospitalization)

When	Name of hospital	For what kind of problem

Psychiatric medication(s)

Name of medication	Dose	Reason for taking medication	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 (please specify):

Has the child ever been evaluated for a behavioral health problem in a hospital emergency room or by a 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
- ○ Other (e.g., community based programs, after school programs)

MEDICAL

Which of the following medical problems has the child had, either currently or in the past?

- ○ Allergies (specify):
- ○ Anemia
- ○ Asthma
- ○ Blood cholesterol problems
- ○ Brain infection (meningitis, encephalitis)
- ○ Cancer
- ○ Diabetes
- ○ Dizzy/fainting spells
- ○ Head injury
- ○ Headaches
- ○ Heart problems (chest pain, pounding heart, murmur)
- ○ Kidney problems
- ○ Liver problems (hepatitis)
- ○ Obesity
- ○ Seizures
- ○ Sexually transmitted infections
- ○ Stomach or intestine problems (celiac, colitis)
- ○ Thyroid problems
- ○ Trouble hearing
- ○ Trouble seeing
- ○ No medical problems
- ○ Other (specify):

Does the child take medication for any of these problems? ○ Yes ○ No

If yes, please specify:

When was the child's last physical exam?

To your knowledge, what were the results of the physical? ◯ Normal ◯ Abnormal

Has the child been hospitalized for an injury, surgery, or other non-psychiatric illness? ◯ Yes ◯ No

If yes, please specify below:

When	Problem

Does the child have other medical providers at BCH? ◯ Yes ◯ No

List all medications (including psychiatric):

BIRTH AND EARLY DEVELOPMENT

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

- ◯ Anemia
- ◯ Bleeding
- ◯ High blood pressure (toxemia)
- ◯ High or low blood sugar
- ◯ Infection
- ◯ Injury to abdomen
- ◯ Seizures
- ◯ Stress or depression
- ◯ Use of alcohol
- ◯ Use of cigarettes

- ◯ Use of medicine prescribed by a doctor (specify):
- ◯ Use of street drugs (specify):
- ◯ Victim of violence
- ◯ No pregnancy problems
- ◯ I don't know

Which of the following problems did the birth mother or the child have **during or after the child's birth**?

- ◯ No labor/delivery problems
- ◯ Birth injury or defects in child
- ◯ "Blue baby" (lack of oxygen at birth)
- ◯ Breech or forceps delivery
- ◯ C-section
- ◯ Hospital intensive care for the child
- ◯ Infection in mother or child at delivery
- ◯ Low birthweight
- ◯ Postpartum depression in the mother
- ◯ Premature delivery
- ◯ Yellow jaundice
- ◯ I don't know
- ◯ Other (specify):

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

SCHOOL

Is your child in school/childcare? ◯ Yes ◯ No

If "Yes" select school environment:

- ◯ Early childhood education
- ◯ Preschool
- ◯ Online classroom
- ◯ Homeschooled
- ◯ Ungraded classroom
- ◯ Graded classroom

What grade is the child in this year?

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? (Check all that apply.)

- ◯ Autism
- ◯ Emotional/Behavioral
- ◯ Learning
- ◯ Neurological
- ◯ Sensory (hearing/vision)
- ◯ Speech/Language
- ◯ If other please describe:

What are the child's usual grades?

- ◯ Mostly As or Bs (4s)
- ◯ Mostly Cs (3s)
- ◯ Mostly Ds (2s)
- ◯ Mostly Fs (1s)

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 factors 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
Homework:	◯ Good	◯ Average	◯ Poor
Friendships:	◯ Good	◯ Average	◯ Poor
Schoolwork:	◯ Good	◯ Average	◯ Poor
Classroom behavior:	◯ Good	◯ Average	◯ Poor
Enjoyment of school:	◯ Good	◯ Average	◯ Poor

COMMUNITY ACTIVITIES

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

- ◯ After-school program
- ◯ Part-time employment
- ◯ Sports league
- ◯ Summer camp
- ◯ Music, art, or dance lessons
- ◯ Religious activities
- ◯ Volunteer activities
- ◯ Other (specify):

SOCIAL HISTORY

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

- ◯ Married
- ◯ Partnered
- ◯ Widowed
- ◯ Separated or divorced
- ◯ Never married

What is the child's current living situation?

- ◯ Living with parent(s)/guardian(s)
- ◯ Living with other family member(s)
- ◯ Foster care
- ◯ Residential/group home
- ◯ Department of Youth Services
- ◯ Shelter
- ◯ Other (specify):

Is the child's current housing situation stable? ◯ Yes ◯ No

If no, please explain:

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

FAMILY HEALTH HISTORY

To your knowledge, have any of the child's parents or siblings had any of the following health conditions?

Health problems	Parent	Sibling
Attention-Deficit/Hyperactivity	○	○
Anxiety	○	○
Autism	○	○
Bipolar	○	○
Depression	○	○
Developmental disability	○	○
Diabetes	○	○
Drug or alcohol abuse	○	○
Heart disease	○	○
High blood cholesterol	○	○
Intellectual disability	○	○
Learning disability	○	○
Obesity	○	○
Obsessions/compulsive disorder	○	○
Schizophrenia	○	○
Seizures	○	○
Suicide death	○	○
Sudden death from heart attack before age 50	○	○
Tics/Tourette's	○	○
None of the above	○	○

STRESSFUL EVENTS

Adopted from the Pediatric ACEs and Related Life-events Screener (PEARLS)

Which of the following events has **ever** happened to the child?

Part 1	Yes	No
1. Has your child ever lived with a parent/caregiver who went to jail/ prison?	○	○
2. Do you think your child ever felt unsupported, unloved and/or unprotected?	○	○
3. Has your child ever lived with a parent/caregiver who had mental health issues? *(for example, depression, schizophrenia, bipolar disorder, PTSD, or an anxiety disorder)*	○	○
4. Has a parent/caregiver ever insulted, humiliated, or put down your child?	○	○
5. Has the child's biological parent or any caregiver ever had, or currently has a problem with too much alcohol, street drugs or prescription medications use?	○	○
6. Has your child ever lacked appropriate care by any caregiver? *(for example, not being protected from unsafe situations, or not cared for when sick or injured even when the resources were available)*	○	○
7. Has your child ever seen or heard a parent/caregiver being screamed at, sworn at, insulted or humiliated by another adult? **OR** has your child ever seen or heard a parent/caregiver being slapped, kicked, punched beaten up or hurt with a weapon?	○	○
8. Has any adult in the household often or very often pushed, grabbed, slapped or thrown something at your child? **OR** has any adult in the household ever hit your child so hard that your child had marks or was injured? **OR** has any adult in the household ever threatened your child or acted in a way that made your child afraid that they might be hurt?	○	○
9. Has your child ever experienced sexual abuse? *(for example, anyone touched your child or asked your child to touch that person in a way that was unwanted, or made your child feel uncomfortable, or anyone ever attempted or actually had oral, anal, or vaginal sex with your child)*	○	○
10. Have there ever been significant changes in the relationship status of the child's caregiver(s)? *(for example, a parent/caregiver got a divorce or separated, or a romantic partner moved in or out)*	○	○
Add up the "yes" answers for this first section:		

Which of the following events has **ever** happened to the child?

Part 2	Yes	No
1. Has your child ever seen, heard, or been a victim of violence in your neighborhood, community or school? *(for example, targeted bullying, assault or other violent actions, war or terrorism)*	○	○
2. Has your child experienced discrimination? *(for example, being hassled or made to feel inferior or excluded because of their race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disabilities)*	○	○
3. Has your child ever had problems with housing? *(for example, being homeless, not having a stable place to live, moved more than two times in a six-month period, faced eviction or foreclosure, or had to live with multiple families or family members)*	○	○
4. Have you ever worried that your child did not have enough food to eat or that the food for your child would run out before you could buy more?	○	○
5. Has your child ever been separated from their parent or caregiver due to foster care, or immigration?	○	○
6. Has your child ever lived with a parent/caregiver who had a serious physical illness or disability?	○	○
7. Has your child ever lived with a parent or caregiver who died?	○	○
Add up the "yes" answers for the second section:		