CHILD PSYCHIATRIC QUESTIONNAIRE

Developed by
Thomas W. McCormack, M.D.

Dear Patients/Parents/Caretakers: Please carefully fill in this form prior to your first appointment in order to help us reduce the time and cost of gathering this information at our office. We appreciate your cooperation and patience.

Patient’s Name: ____________________________________________

Date of Birth: ____/____/____  Patient’s Birthplace:__________________  Sex: □ M  □ F

Race: □ African-American  □ Caucasian  □ Latino  □ Asian  □ Other ________________

Person completing this form:_______________________  Relation to child:_________________

• Who referred you for an evaluation? ________________________________________________

• Please briefly describe the problems for which you are seeking help at this time.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

• Approximately when did the problem(s) begin? _________________________________________

____________________________________________________________________________________
____________________________________________________________________________________

• Any known stress cause or contribute to the problem(s)? □ No  □ Yes

If Yes, please describe stress:__________________________________________________________
- Has the patient ever received outpatient mental health treatment?  
  - No  
  - Yes

  *If yes, please list in order, including Psychological or IQ/School testing:*

<table>
<thead>
<tr>
<th>Clinician/ Doctor</th>
<th>Date(s) of Evaluation or Treatment</th>
<th>Type of Evaluation or Treatment</th>
<th>Frequency of visits</th>
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- Has the patient ever received inpatient mental health treatment?  
  - No  
  - Yes

  *If yes, please list in order:*

<table>
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<tr>
<th>Hospital Name</th>
<th>Dates of Treatment</th>
<th>Reason for hospitalization</th>
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- If your child has ever taken psychiatric medications, please list them below:  
  - Not applicable

<table>
<thead>
<tr>
<th>Rx Name</th>
<th>Reason Given</th>
<th>Highest Dose</th>
<th>% Improvement</th>
<th>Side-effects</th>
<th>Dates Taken</th>
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- Has your child ever threatened or attempted suicide?  
  - No  
  - Yes  
  *If yes, please describe:*

  ____________________________________________________________
  ____________________________________________________________

- Has your child ever had any brain imaging or functional studies? (MRI, CAT scan, EEG, etc.)  
  - No  
  - Yes
**Family Psychiatric History:**  
(Please note ADHD, Learning Disorders, Depression, Bipolar Disorder, Anxiety Disorders, Obsessive-Compulsive Disorder, Tic/Tourette’s, Schizophrenia, Drug or Alcohol Abuse, Suicide attempts, or other Psychiatric Problems).

- Is there a history of ADHD, mental illness, mental retardation, learning problems, alcohol or drug abuse in the patient’s grandparents, parents, siblings, or 1st cousins?…………………☐ No ☐ Yes
  
  *If Yes, please fill in the following chart:

<table>
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<tr>
<th>Affected Family Member</th>
<th>Type of Mental Illness or SA</th>
<th>Treatment (if any)</th>
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**Childhood Development:**

- **Pregnancy**—Please check any that apply to the mother’s pregnancy with this child:

  - Received prenatal care
  - Drank alcohol during pregnancy
  - Smoked during pregnancy
  - Used drugs during pregnancy
  - Took medications
  - Infection(s)
  - Nausea or Vomiting
  - Severe Emotional Distress
  - Elevated blood pressure
  - Diabetes of pregnancy
  - Pre-eclampsia
  - Premature labor
  - Threatened miscarriage

  **Describe**

  _______________________________________________

**Birth History:**

Mother’s age at time of birth: ____ years old.  
Father’s age at time of birth: ____ years old.

Was mother given medication or anesthesia?________☐ Don’t know ☐ No ☐ Yes

Delivery was: __________________________☐ Spontaneous Vaginal ☐ Induced ☐ Caesarian section

Any complications with labor or delivery?______________ ☐ No ☐ Yes __________

Was the baby premature? ____________________________ ☐ No ☐ Yes __________

Baby’s birthweight: ____ lbs ____ oz

Did baby have any of the following:  
- Breathing problems________☐ No ☐ Yes
- Cord around the neck________☐ No ☐ Yes
- Abnormal color __________☐ No ☐ Yes
- Abnormal tone __________☐ No ☐ Yes
- Meconium __________☐ No ☐ Yes
- Failure to thrive __________☐ No ☐ Yes
- Jaundice __________☐ No ☐ Yes
- Infection __________☐ No ☐ Yes
**Developmental Milestones** *(answer as best you can recall)*

Motor Development (sitting, crawling, walking) ................. □ Normal □ Fast □ Slow
Speech & Language .......................................................... □ Normal □ Fast □ Slow
Self-help skills (dressing, brushing, toileting, hygiene) ........ □ Normal □ Fast □ Slow

**Temperament as Infant:** □ Easy baby □ Slow to Warm up □ Difficult/ “Colicky”

**Medical History:**

- Who is your child’s Pediatrician or Family Doctor? ________________________________
- When was your child’s last physical examination? ________________________________
- Current Medications *(include Over-the-counter meds, Vitamins, Herbs, or Supplements)*
  □ None OR Please List:

<table>
<thead>
<tr>
<th>Rx Name</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Prescribing M.D.</th>
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- Does your child have any drug allergies? □ No □ Yes *(please list):*

____________________________________________________________________________

- Does your child have any current medical problems? □ No □ Yes *(please list):*

____________________________________________________________________________

- Please check & briefly describe if your child has experienced any of the following conditions:
  □ Surgeries _________________________________________________________________
  □ Chest pain _______________________________________________________________
  □ Abnormal heart rate or rhythm _____________________________________________
  □ High Blood Pressure _______________________________________________________  
  □ Seizures/Convulsions _______________________________________________________  
  □ Staring spells _____________________________________________________________
  □ Head injury ______________________________________________________________
  □ Frequent Strep Throat infections _____________________________________________
  □ Frequent Headaches _______________________________________________________
  □ Frequent Stomach Aches _____________________________________________________
  □ Vision problems __________________________________________________________
  □ Hearing problems _________________________________________________________
  □ Significant accidents or injuries ___________________________________________
  □ Bedwetting _______________________________________________________________
  □ Fecal soiling of clothes ____________________________________________________
  □ Exposure to Lead or Mercury _______________________________________________
Social History:
- City of Residence: _________________________
- Now Living with: □ Both Bio parents   □ Bio Father   □ Bio Mother   □ Other: _____________
- Other Children in family:
  Names & Ages: ___________________________               ___________________________
                                                                          ___________________________
- Is the child adopted?.................................................................................................................. □ No   □ Yes
  If Yes, Please describe the circumstances of the adoption: ________________________________________
- Has the patient ever experienced or witnessed any physical abuse, sexual abuse, or neglect? □ No   □ Yes
  If Yes, please briefly describe: _____________________________________________________________
- Hobbies/ Interests: ____________________________________________________________
- Any concerns about peer relationships/ social skills? ____________________________

School History:
- Name of School: _____________________________________                    Grade: __________
- Current Academic Performance: .................................. □ Good   □ Fair   □ Poor
- Past Academic Performance: ...................................... □ Good   □ Fair   □ Poor
- Current Behavioral Performance: .................................. □ Good   □ Fair   □ Poor
- Past Behavioral Performance: ...................................... □ Good   □ Fair   □ Poor
- Grades Repeated: __________
- Is child in any special education programs? ........................................ □ No   □ Yes (explain):
- Any known Learning Disabilities? .......................................... □ No   □ Yes (explain):

Legal Problems:
- Has your child has ever been arrested or had legal charges? ............. □ No   □ Yes (explain):

Substance Use:
- Do you suspect that your child has ever used tobacco, alcohol, or drugs? □ No   □ Yes (explain):

Religious Beliefs:
□ None   □ Jewish   □ Muslim   □ Hindu   □ Christian (denomination) _________________   □ Other