



Texas Tech University

Health Sciences Center

School of Medicine

This questionnaire helps us gather information about your child and family that will be helpful in determining the type of treatment which would most likely help the problems your child is expecting. Please fill out all of the questions completely as possible.

I. Identifying Information

Child's Name: _____
Last First Middle

Address: _____
Street City State Zip

Date of Birth ____/____/____ Current age ____ Ethnicity: White Hispanic Afr. Amer. Asian Other

Grade: _____ School _____ District: _____

Legal Guardian Bringing Child for Treatment _____ Relationship to child _____

II. Parents (if parents are separated, please circle parent child lives with most of the time)

Mother: _____ Hm Phone: _____ Wrk Phone: _____

Father: _____ Hm Phone: _____ Wrk Phone: _____

III. Marital History

	Date of marriage	Date of Divorce/Widowed (If applicable)	Name of Step-Parent
Child's Bio/Adoptive Parent	_____	_____	_____
Mother's 2 nd Marriage	_____	_____	_____
Father's 2 nd Marriage	_____	_____	_____
Mother's 3 rd Marriage	_____	_____	_____
Father's 3 rd Marriage	_____	_____	_____

If parents are separated, does the non-custodial parent want to be involved in the treatment of the child? () Y () N

If YES: do you think the non-custodial parent will object to medication or counseling for your child? () Y () N

C. Did you have any difficulties during your pregnancy or during child birth? If yes, please describe:

VII. Development

At what age did your child:

Hold his/her head up _____ Smile _____ Sit up _____

Take first steps _____ Walk _____ Run _____

Babble, coo _____ Say first words _____ Use sentences _____

Toilet trained _____ Was toilet training easy/hard? _____

Did he/she suffer from colic? If yes, please describe: _____

As an infant or toddler did your child have trouble attaching or bonding to either parent? If yes, please describe: _____

Did he/she have or had any speech delays or problems? _____

Does he/she have problems with poor motor coordination (being clumsy?) _____

If yes, please describe: _____

Does your child have a main best friend? Yes No

Does your child have a steady group of friends? Yes No

Does your child have trouble making friends? Yes No

Does he/she have trouble keeping friends? Yes No

Does he/she have friends who get him/her in trouble? Yes No

Is he/she a leader or a follower? _____

Do neighbors tell their child not to interact with your child? Yes No

Do other children think your child is "weird" or "odd"? Yes No

Do other children think your child is mean? Yes No

Does he/she play mostly with younger children? Yes No

Do teachers/day care workers say your child doesn't get along with other children? Yes No

VIII. Child's Schooling

Please list the schools your child has attended since Kindergarten:

Grade School	Teacher reported behavior or learning problems?		In Special Education?	
	Yes	No	Yes	No
K _____	Yes	No	Yes	No
1 st _____	Yes	No	Yes	No
2 nd _____	Yes	No	Yes	No
3 rd _____	Yes	No	Yes	No
4 th _____	Yes	No	Yes	No
5 th _____	Yes	No	Yes	No
6 th _____	Yes	No	Yes	No
7 th _____	Yes	No	Yes	No
8 th _____	Yes	No	Yes	No
9 th _____	Yes	No	Yes	No
10 th _____	Yes	No	Yes	No
11 th _____	Yes	No	Yes	No
12 th _____	Yes	No	Yes	No

IX. Child's Activities

Bedtime on School Days: _____ Weekends/holidays: _____ Sleeps by self? _____

Typical bedtime behavior: Goes to bed easily Argues/resists Scared/needs reassurance

Wets bed? Yes No Nightmares? Yes No Sleepwalking? Yes No Loud snoring? Yes No

Wake up time school days: _____ Wake up time weekends: _____ Hours sleep/night: _____

Avg. hour's television watched on school nights: _____ Weekend: _____

What sports is child involved in? _____

What other structured activities (scouts, church, etc.) is the child involved in? _____

Describe child's computer/internet usage: _____

Each rating should be based on what is appropriate for the age of your child. Please rate child's behaviors observed in the past 6 months, using these frequency codes:

0= **Never** 1=**Occasionally** 2=**Often** 3= **Very Often**

1.	Does not pay attention to details or makes careless mistakes with (i.e.) homework.	0	1	2	3
2.	Has difficulty sustaining attention to tasks/activities.	0	1	2	3
3.	Does not seem to listen when spoke to directly.	0	1		3
4.	Does not follow through when given directions and fails to finish activities (not due to oppositional behavior or failure to understand).	0	1	2	3
5.	Has difficulty organizing tasks and activities.	0	1	2	3
6.	Avoids, dislikes, or is reluctant to start tasks that require continuous mental effort.	0	1	2	3
7.	Loses things necessary for tasks or activities (toys, assignments, pencils, books).	0	1	2	3
8.	Is easily distracted by noises or other stimuli around him/her.	0	1	2	3
9.	Is forgetful in daily activities.	0	1	2	3
10.	Fidgets with hands or feet or squirms in seat.	0	1	2	3
11.	Leaves seat when remaining seated is expected.	0	1	2	3
12.	Runs or climbs too much when remaining seated is expected.	0	1	2	3
13.	Has difficulty playing quietly.	0	1	2	3
14.	Is "on the go" or acts as if "driven by a motor".	0	1	2	3
15.	Talks too much.	0	1	2	3
16.	Blurts out answers before the questions have been completed/	0	1	2	3
17.	Has difficulty waiting his or her turn.	0	1	2	3
18.	Interrupts/intrudes on others (i.e. butts into conversations or games).	0	1	2	3
19.	Argues with adults.	0	1	2	3
20.	Loses temper.	0	1	2	3
21.	Actively defies/refuses to go along with adults' request or rules.	0	1	2	3
22.	Deliberately annoys people.	0	1	2	3
23.	Blames other for his/her mistakes/misbehaviors.	0	1	2	3
24.	Is touchy or easily annoyed by others.	0	1	2	3
25.	Is angry or resentful.	0	1	2	3
26.	Is spiteful and vindictive (i.e. wants to get even).	0	1	2	3
27.	Bullies, threatens, or intimidates others.	0	1	2	3
28.	Starts physical fights.	0		2	3
29.	Lies to obtain goods or to avoid obligations (i.e. "cons" others).	0	1	2	3
30.	Is truant from school (skips school) without permission.	0	1	2	3

31.	Is physically cruel to people.	0	1	2	3
32.	Has stolen things that have value.	0	1	2	3
33.	Deliberately destroys others' property.	0	1	2	3
34.	Used a weapon that can cause serious harm (bat,knife,brick,gun).	0	1	2	3
35.	Is physically cruel to animals.	0	1	2	3
36.	Has deliberately set fires to cause damage.	0	1	2	3
37.	Has broken into someone else's home, business, or car.	0	1	2	3
38.	Has stayed out at night without permission.	0	1	2	3
39.	Has run away from home.	0	1	2	3
40.	Has forced someone into sexual activity.	0	1	2	3
41.	Is fearful, anxious, or worried.	0	1	2	3
42.	Is afraid to try new things for fear of making mistakes.	0	1	2	3
43.	Feels worthless or inferior.	0	1	2	3
44.	Blames self for problems, feels guilty.	0	1	2	3
45.	Feels lonely, unwanted or unloved: sys that "no one loves" him/her.	0	1	2	3
46.	Is sad, unhappy, or depressed.	0	1	2	3
47.	Is self-conscious or easily embarrassed.	0	1	2	3

Below is a list of statements that describe how people feel. Read each phrase and decide if it is "not true or hardly ever true", or "somewhat true or sometimes true" or "very true or often true" for your child. Then for each sentence, circle the number that corresponds to the response that seems to describe your child for the last 3 months.

		Not true; hardly ever true	Somewhat true: sometimes true	Very true; often true
1.	My child gets really frightened for no reason at all.	0	1	2
2.	My child is afraid to be alone in the house.	0	1	2
3.	People tell me that my child worried too much.	0	1	2
4.	My child is scared to go to school.	0	1	2
5.	My child is shy.	0	1	2

This form is about how your child might have been feeling or acting recently.

For each question, please check how much he or she has felt or acted this way in the past 2 weeks.

If a sentence was true most of the time, circle 2= TRUE. If it was only sometimes true, circle 1= SOMETIMES. If a sentence was not true, circle 0= NOT TRUE.

		NOT TRUE	SOME-TIMES	TRUE
1	He/she felt miserable or unhappy.	0	1	2
2	He/she didn't enjoy anything at all.	0	1	2
3	He/she was less hungry than usual.	0	1	2
4	He/she ate more than usual.	0	1	2
5	He/she felt so tired he/she sat around and did nothing.	0	1	2
6	He/she was moving and walking more slowly than usual.	0	1	2
7	He/she was very restless.	0	1	2
8	He/she felt he/she was no good no more.	0	1	2
9	He/she blamed himself/her for things that weren't his/her fault.	0	1	2
10	It was hard for him/her to make up his/her mind.	0	1	2
11	He/she felt grumpy and cross with you.	0	1	2
12	He/she felt like talking less than usual.	0	1	2
13	He/she was talking more slowly than usual.	0	1	2
14	He/she cried a lot.	0	1	2
15	He/she thought there was nothing good for him/her in the future.	0	1	2
17	He/she thought life wasn't worth living.	0	1	2
18	He/she thought about death or lying.	0	1	2
19	He/she thought his/her family would be better off without him/her.	0	1	2
20	He/she thought about killing himself/her.	0	1	2
21	He/she found it hard to think properly or concentrate.	0	1	2
22	He/she thought bad things would happen to him/her.	0	1	2
23	He/she hated himself/her.	0	1	2
24	He/she felt he/she was a bad person.	0	1	2
25	He/she thought he/she looked ugly.	0	1	2
26	He/she worried about aches and pains.	0	1	2
27	He/she felt lonely.	0	1	2
28	He/she thought nobody really loved him/her.	0	1	2
29	He/she didn't have any fun at school.	0	1	2
30	He/she thought he/she could never be as good as other kids.	0	1	2
31	He/she felt he/she did everything wrong.	0	1	2
32	He/she didn't sleep as well as he/she usually sleeps.	0	1	2
33	He/she slept a lot more than usual.	0	1	2
34	He/she wasn't as happy as usual, even when praised or rewarded him/her.	0	1	2

The following questions concern your child's mood and behavior in the **past month**. Please place a check mark or an 'X' in a box for each item. Please consider it a problem if it is **causing trouble** and is beyond what is normal for your child's age. Otherwise, check 'rare or never' if the behavior is not causing trouble.

	Does your child...	Never rarely	Some times	Often	Very often
1	Have periods of feeling super happy for hours or days at a time, extremely wound up and excited, such as feeling "on top of the world"	0	1	2	3
2	Feel irritable, cranky, or mad for hours or days at a time.	0	1	2	3
3	Think that he/she can be anything or do anything (i.e., leader, best basketball player, rap singer, millionaire, princess) beyond what is usual for that age	0	1	2	3
4	Believe that he/she has unrealistic abilities, or powers that are unusual, and may try to act upon them, which causes trouble	0	1	2	3
5	Need less sleep than usual: yet does not feel tired the next day	0	1	2	3
6	Have periods of too much energy	0	1	2	3
7	Have periods when he/she talks too much or too loud or talks a mile minute	0	1	2	3
8	Have periods of racing thoughts that his/her mind cannot slow down, and it seems that your child's mouth cannot keep up with his/her mind	0	1	2	3
9	Talk so fast that he/she jumps from topic to topic	0	1	2	3
10	Rush around doing things nonstop	0	1	2	3
11	Have trouble staying on track and is easily drawn to what is happening around him/her	0	1	2	3
12	Do many more things than usual, or is unusually productive or highly creative	0	1	2	3
13	Behave in a sexually inappropriate way (i.e., talks dirty, exposing, playing with private parts, masturbating, making sex phone calls, humping on dogs, playing sex games, touches others sexually)	0	1	2	3
14	Go and talk to strangers inappropriately, is more socially outgoing than usual	0	1	2	3
15	Do things that are unusual for him/her that are foolish or risky (i.e., jumping off heights, ordering CDs with your credit cards, giving things away)	0	1	2	3
16	Have rage attacks, intense and prolonged temper tantrums	0	1	2	3
17	Cracks jokes more than usual, laugh loud or act silly in a way that is out of the ordinary	0	1	2	3
18	Experience rapid mood swings	0	1	2	3
19	Have suspicious or strange thoughts	0	1	2	3
20	Hear voices that nobody else can hear	0	1	2	3
21	See things that nobody else can see	0	1	2	3

Traumatic Events

In this form, we ask questions about things that sometimes happen to kids and teenagers. Some of these things may have been upsetting or scary to your child. If the event has never occurred to your child, please mark the box under the word "No". If the event has occurred but was not upsetting or scary to your child, please mark the box under the word "Yes". If the event occurred and was scary/upsetting to your child, please mark the box under that choice. Please think carefully about each question. We may talk to you further about your answers. Please mark the appropriate box for each question.

		YES	NO	Yes;was upsetting or scary
1	Has your child ever been in a really bad accident? i.e. car accident, fall or a fire?			
2	Has your child ever witnessed a really bad accident that he/she was not in?			
3	Has your child ever been in a really bad storm, like a tornado, hurricane, or a blizzard? Or a flood, or earthquake? Or was your child ever been struck by lightning?			
4	Has your child ever known someone who got really hurt or sick or even died?			
5	Has someone ever attacked your child or tried to hurt your child really bad on purpose?			
6	Has someone ever told your child that they were going to hurt him/her really badly, or acted like they were going to hurt him/her badly?			
7	Has someone a lot older tried to rob or steal from your child?..Or mug your child?			
8	Has someone ever kidnapped your child or taken your child away when they weren't supposed to?			
9	Has your child ever seen people not in your family fighting/attacking each other? Or shooting with a gun? Or stabbing with a knife? Or beating each other up?			
10	Even if they were weren't physically attacking each other, has your child ever heard people in your family yelling and screaming at each other a lot?			
11	Has someone ever touched your child's body's private parts in a way that your child didn't want or that made your child feel uncomfortable? Or made your child touch their body's private parts? Or made your child do something sexual that your child didn't want to do?			
12	Has anyone ever physically hurt or injured your child really badly on purpose?			
13	Has there been some other time when something happened that really made your child feel scared or upset, or that bothers your child a lot now? What happened?			

If you said yes to any of the above events:

Do you worry your child's current problems are related to the traumatic events?	YES	NO
Does your child ever seem like he/she is re-living the trauma?	YES	NO
Does he/she have lots of nightmares about the trauma?	YES	NO
Does he/she have flashbacks about the trauma?	YES	NO

Family History

If your family members have history of mental illness, or have mental illness at present, please write the **"X"** sign in the box under the group that it applies to (mother, father, sibling or others). If you are not sure but suspect that they have mental illness, please write a question mark **"?"** in the appropriate box. If family members don't have mental illness, please leave the boxes **empty**.

Disorder:	Mother	Father	Siblings	Others	Comment
1) ADHD					
2) Learning Disability					
3) Mental Retardation					
4) Psychosis/Schizophrenia					
5) Manic depressive/bipolar disorder					
6) Major depressive disorder					
7) Suicide					
8) Anxiety Disorder					
9) Tics/Tourette syndrome					
10) Alcohol Abuse					
11) Substance Abuse					
12) Inpatient psychiatric hospitalization					
13) Epilepsy/Seizures					
14) Other mental problems:					

Name of person filling out form

Relationship to child

Signature

Date

Reviewed by clinician: _____

Date: ____/____/____

Treatment Goals Checklist

This information is being collected under the authority of the Health and Social Service Authority in order to provide services. It is protected by the privacy provisions of the Access to information and Protection of Privacy (ATIPP). If you have questions about the collection or use of the information, please contact the manager/supervisor at the program providing the service. (The receptionist can direct you to the manager or supervisor)

Client Name: _____

Date: _____

The following is a list of goals that people coming to treatment sometimes have. Please indicate what your present goals are by circling yes and which are not your present goals by circling no.

- | | | |
|---|-----|----|
| 1. To deal with my problem of alcohol and/or drug use and/or gambling. | Yes | No |
| 2. To learn to manage stress appropriately. | Yes | No |
| 3. To learn to stand up for myself better. | Yes | No |
| 4. To be able to deal with my feelings and express them directly. | Yes | No |
| 5. To improve my relationship with members of my family
(spouse, children, parents, etc.). | Yes | No |
| 6. To be able to get along better socially. | Yes | No |
| 7. To improve my ability to find and keep a job. | Yes | No |
| 8. To learn to use my leisure time better. | Yes | No |
| 9. To improve my living arrangements. | Yes | No |
| 10. To deal effectively with my financial problems. | Yes | No |
| 11. To deal effectively with my legal problems. | Yes | No |
| 12. To deal effectively with my medical problems. | Yes | No |
| 13. To manage my emotional/mental health issues appropriately. | Yes | No |
| 14. Other-Please specify _____ | Yes | No |

Summary

How many goals have you indicated? _____

Of the goals you indicated, which are the most important for you to solve at the moment?

My first most important goal is # _____

My second most important goal is # _____

My third most important goal is # _____