

DO NOT USE CHILD'S NAME OR OTHER INFO THAT WILL REVEAL THEIR OR YOUR IDENTITY

Naval Medical Center Portsmouth/BHC NAS Oceana Child and Adolescent Psychology Clinic

## CLIENT DATA QUESTIONNAIRE

Use this ID only to ID child- > > XX-XXX

To assist your child or teenager at the NMCP Child/Adolescent Psychology Clinic your support is crucial. Responses on this questionnaire provide a better understanding of your child or teenager and a more accurate clinical opinion of their unique situation. If they have been prescribed psychiatric medication, please consider their behavior when they were off medication when you respond. When this questionnaire is reviewed an opportunity will be provided for you to share any changes you see with medication use. If you are unsure about an item, or do not feel comfortable with a question, please leave it blank. There are opportunities throughout the questionnaire to add any other comments.

Your willingness to complete this questionnaire is greatly appreciated. We look forward to working with you.

**General Instructions:** Please read any special instructions for each section of the questionnaire. Generally, you will be requested to enter an "X" next to the item if it applies to your child or teen. If never seen leave it blank. Other items will ask you to "fill in the blank" or complete a "table form". If you are unsure about a term or item just leave it blank and we will review it during the parent interview. If you want to say more about an item, you might wait until after you have completed the entire questionnaire. Then you can return to those items and use space provided on the "Any other Comments" section for additional comments/concerns. Please follow directions for return of this form. Call 953-7641 for questions-ask for "child clinic".

**Save this to your hard drive often during completion. When done email it back to person who sent it to you.**

**Please enter responses in light blue spaces only**

**REFERRAL SOURCE:** (If self-referred, please enter "self" and complete the next sections.)

Name of health care practitioner (HCP) who referred you:

**Please state what you understand is the reason that they referred you here in the space below;**

**When is the next time you are scheduled to see the HCP or visit that clinic again? Reason for that visit?**

**PRESENTING PROBLEMS:** Please list the top three concerns that you have about your child or teenager, and the age at which they began.

1-)

2-)

3-)

**PAST ASSISTANCE OR MEDICATION FOR CHILD / TEEN'S BEHAVIORAL / EMOTIONAL ISSUES**

(Include therapy, school based counseling, ADHD meds from PCM, child study team. If none, please enter "none" and skip to next section.)

<b>Provider Name/Discipline:</b>	<b>Last seen?</b>	<b>Reason seen?</b> (Also include any psychologicals/reports conducted. Please provide copies.)

**BEHAVIOR CHECKLIST:** If you observe an item below enter a "X" (for "Yes") to the right of the item. If never seen leave blank. If you need need to say more about a certain item, wait until you are done with the checklist. Then, return to checked items using "Any other Comments" section for your comments. Also use that section to add symptoms that are not listed below. You may add symptoms under "Other" below.

**If there are multiple choices within a certain item enter "Y". We will clarify what applies to your child after you return form.**

<b>Activity</b>	<b>Eating</b>	<b>Perception/Motor (continued)</b>	<b>Substance Use</b>
Agitated	Appetite problem/Picky eater	Sees "things" as falls asleep	Associate w/negative peers
Appears "jumpy", startles easily	Binge Eating	Sees "things" as awakens	Attitude change, secretive
Disorganized Activity	Difficult keep normal weight	Sense of unreality	Overcounter/prescription
Expansive/Ignores boundaries	Laxative to control weight	Tics (physical/vocal/___)	School, others believe use
Hyperactive ("hyper", fidgets)	Self-induced vomiting	Unusual movement, posture	Uses alcohol
Low activity or energy	Significant weight gain/loss	Vision problems/Disturbances	Uses other drugs
<b>Anxiety/Phobias</b>	<b>Learning Issues</b>	<b>Physical symptoms</b>	<b>Thinking</b>
Anxiety/Anxious	Dyslexia, right-left confusion	Allergy, asthma, tiredness	Bizarre thoughts
Fears	Handwriting problem/delay	Palms sweat, skin clammy	Bizarre preoccupation
Looks Worried	Reading problem/delay	Heart murmur, racing pulse	Confused thinking
Panic attacks/Intense fright	Math problem/delay	Itches, eczema, acne	Denies what he/she did
Physical anxiety symptoms	Problems with organization	Pain symptoms/headaches	Delusions(rigid false belief)
Safety Concern(Door	Spelling problem/delay	Seizure, restless legs	Excess/Inappropriate guilt



**FAMILY / PARENTING HISTORY**

**List in home parental figures serving in a parent role for any significant period of time:**

	Biological Father	Biological Mother	StepMother	StepFather	Other parent figures residing within home:
Parent Name					
Occupation					
Lives with child now?					
Age lived w/parent figure					
How close child to parent					
Relationship Quality					
How is child is similar to this parent					
Physical Health Issues					
Mental Health Issues					
Discipline Type Used					

**List all of the child/teen sibling's (biological, "step-sibling", adopted)**

Sibling Name					
Age					
Relation (e.g., "step sister")					
Age lived with client					
Lives with child @ present?					
Relationship Quality					

How is child is similar to this sibling?					
Physical Health Issues					
Mental Health Issues					

**List mental health issues for biological mother/father's family(ADHD, depression, bipolar, behavior, learning, alcohol, etc.)**

**FAMILY / PARENTING HISTORY (Continued)**

Biological (birth) parents married for how man years and parents relationship described as?

If biological parent's marriage ended in divorce OR involved a separation (circle which) OR if either were married previously, describe these marriages, why the divorce and present nature of the post-divorce relationship.

**SOCIAL HISTORY**

How many moves since birth & at what age/grade/locations did these moves occur & child's reaction?

**Relations with others:** Consider your child/teen's relationship with others and enter a "X" if item applies.

Aggressive/Fights/Quarrels		Immature/Easy frustrated		Repeat peer negative behavior		Seeks out friends	
Does not share/play fair		Interested in objects not,		Knows social cues/norms		Leader/popular	
Easily hurt/Sensitive		people, socially detached		Sought out by peers		Able to engage in "give & take"of social interactions	

**Community/Extended Family Contacts:** For each of the following items enter a "X" if item applies.

Child ever placed out of home	Foster children in home	Family outings (movie/picnic)	Use community center
Child Protection Contact	Attend community activity/event	Family Vacations	Visits to Museum/Theatre
Court/Juvenile system contact	Attend Sporting Events	Frequent deployments/dets	Visits w/ grandparents
Family Advocacy (FAP)	Extended family "gatherings"	Friends visit house	and/or extended family

**Main interests, hobbies and sports** (include below any that also used to be areas of particular interest to your child or teen.)

## BIRTH AND DEVELOPMENTAL HISTORY

### PREGNANCY AND DELIVERY

(Use "Any Other Comment" section at end if needed)

Length of pregnancy (weeks): \_\_\_ Mothers age when child born: \_\_\_

Child Birth Wt: \_\_\_\_\_  
(lbs and ounces)

Labor and Delivery in hrs: \_\_\_\_\_

**Place "X" if occurred during pregnancy**

**Place "X" if occurred during/after delivery**

Excessive weight gain (30lb+)	Emotional/ Psychological Stress
Excessive/Unusual Bleeding	Physical/Emotionally Abused
High Blood Pressure/ Preeclampsia	Prescription Meds by mother
Rh fr/Measles/Illness/Diabetes	Used Alcohol
Frequent Nausea/Vomiting	Pot/Illegal drugs
Call to OB/GYN after hours	Cigarettes

Medication to ease labor pain	
Forceps were used	
Breech/Cesarean/Induced	
Baby Injured during delivery	
Heart stress/Cord around neck	
Trouble breathing/Oxygen	

Was cyanotic/turned blue
Jaundiced/turned yellow
Infection/Seizures
Congenital birth defect
In hospital 7 days or more
Overall delivery uneventful

(Use "Any Other Comment" section at end if needed)

### INFANT HEALTH AND TEMPERAMENT (First 12 months)

**Place "X" if noted during infancy**

Colicky/Difficult to feed/Satisfy	Easy/Hard to comfort
Easy/Hard keep on schedule	Alert/Cheerful
Often/Rarely smiles at others	Affectionate/Sociable

Ignores/Connected to others	
Stubborn/Flexible/Compliant	
Docile/Unmanageable	

Problems with sleep
Easy/Hard to keep busy
Overactive/Unrestrainable

**COMMENT:** (Enter in box to the right) zczxczxczvzvzvzvzvzvzv

**EARLY DEVELOPMENTAL MILESTONES**

Place "X" if any problem or delay in any of the following

Sit up alone	Walking alone-no assistance	Put two or more words together ("mama up")	Bowel trained
Crawling	Single word ("mama", "ball")		Bladder trained

**DESCRIBE:**

Fine motor/Handwriting problems? (examples: pencil grip, drawing, etc)	Gross motor difficulties/Clumsiness? (examples: catch ball, jump rope, etc)
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**PHYSICAL HEALTH**

Health is: Excellent/Good/Poor

Date/reason for last physician contact:

Has child/teen had the following? Enter "P" = Past; "N" = Now; "B" = Both Past & Now. Leave blank if "never had".

Asthma/Allergy/Eczema/Hives:	Heart/Blood pressure issues:	Eats non-food (paper, dirt, etc):	Hearing/Vision problems:
Epilepsy/Seizure/Neurology:	Ear/"Strep" infections/RSV:	Diabetes:	Acne:

Place "X" for each of the following items if seen/occurred.

Soiling/wetting accidents:	Speech/language problems:	Head injury:	Loss of consciousness:
Broken bones/cuts w/ stitches:	High fevers (over 103F):	Febrile seizures due to fever:	Surgery/Hospitalization:

**OTHER ILLNESS/CONDITIONS (List):**

Describe any use of alcohol and/or drugs (age begun, frequency, amount, consequences, etc.):

**SCHOOL**

School behavior rated by parents as: Excellent/ Poor/ Good

School behavior rated by teachers as: Excellent/ Poor/ Good

For above "School behavior" ratings enter underlined letter.  
For below "Academic Concern" ratings enter "X"

Present grade:

**Academic Concerns:**  
Place an "X" if there are issues with

Listening->	<-Reading	Math->
	<-Tests	Homework->

Spelling->	Writing->
Memory->	Reverses Letters->

Most immediate concern about school is:

Place "X" for each of following items seen/occurred (unless requested otherwise)

Did well until grade (enter---->)	Teacher said "has ADHD"	Speech Language Evaluation	Reading Tutor
Repeated grade (enter----->)	Child study team called	Individual Education Plan(IEP)	Bullied by peers in school
Client dislike/hate/resist school	Formal academic testing	504 Plan of accommodation	Liked by teachers
Parents called to school often	Special education class	Reading Resource Class	Liked by other students

(Use "Any Other Comment" section at end if needed)

### OTHER HISTORY

**Legal problems (divorce, custody, delinquency)?**

**Religious background:** Client/family religion is

**Client attend services regularly:**

**How does client behave during attendance?**

**Family conflict about religion?**

**Any other comments about religious/spiritual issues that may be relevant? Does client had sense of "right and wrong"?**

**ANY OTHER COMMENT:** (Please enter below)

Client Data Questionnaire Completed

By:

<--Parent Name here.

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