PRIMARY CARE GIVER INTERVIEW

PLEASE COMPLETE THIS QUESTIONNAIRE AS IT WILL ASSIST IN THE EVALUATION OF YOUR CHILD

Name of child: ____________________ **Age:** ____________

Name of person filling out this form: ____________________

Relationship to child: ____________ **Date:** ____________

Reason for referral:

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Referral Source:

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Parental Objectives:

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DEVELOPMENTAL FACTORS

A - PRENATAL HISTORY:

1 - Mother's health during pregnancy: ( ) Good ( ) Fair ( ) Poor ( ) Unknown

2 - Mother's age when child was born: ( ) Under 20 ( ) 20 - 24 ( ) 25 - 29
( ) 30 - 34 ( ) 35 - 39 ( ) 40 - 44 ( ) 45 + ( ) Unknown

Did mother use any of the following substances during pregnancy:

3 - Beer or wine: ( ) Never ( ) 1-2 times ( ) 3 - 9 times ( ) 10 - 19 times
( ) 20 - 39 times ( ) 40 + times

4 - Hard Liquor: ( ) Never ( ) 1-2 times ( ) 3 - 9 times ( ) 10 - 19 times
( ) 20 - 39 times ( ) 40 + times

5 - Coffee/Caffeine: ( ) Never ( ) 1-2 times ( ) 3 - 9 times ( ) 10 - 19 times
( ) 20 - 39 times ( ) 40 + times

6 - Cigarettes: ( ) Never ( ) 1-2 times ( ) 3 - 9 times ( ) 10 - 19 times
( ) 20 - 39 times ( ) 40 + times

7 - Ingestion of the following substances during pregnancy:

( ) Valium (Librium, Xanax) ( ) Tranquilizers

( ) Antiseizure medications (e.g. Dilantin) ( ) Treatment for Diabetes

( ) Antibiotics (for viral infections) ( ) Sleeping Pills

( ) Other (please specify: ________________________)

B - PERINATAL HISTORY

Did the mother experience any of the following medical conditions:

8 - Toxemia or eclampsia ( ) Yes ( ) No ( ) Unknown

9 - Rh factor incompatibility ( ) Yes ( ) No ( ) Unknown

10 - Was the child born on schedule ( ) 8 months/less ( ) Term 8-10 months ( ) 10 months
( ) Unknown

11 - Duration of labor ( ) Under 6 hours ( ) 7-12 hours ( ) 13-18 hours
( ) 19-24 hours ( ) 24 hours + ( ) Unknown

12 - Was the mother given any medications during labor for pain management?

( ) Yes If yes, please specify names of medications: ____________________________
( ) No ( ) Unknown

13 - Were there any indications of fetal distress during labor or the actual birth?

( ) Yes ( ) No ( ) Unknown

14 - Actual delivery process was:

Vaginal (normal)	( ) Yes	( ) No
Breech	( ) Yes	( ) No
Caesarian	( ) Yes	( ) No
Induced	( ) Yes	( ) No
Use of Forceps	( ) Yes	( ) No

15 - What was the child's birth weight?

( ) 2lbs - 3lbs 15 oz. ( ) 4 lbs - 5 lbs 15 oz. ( ) 6 lbs - 7 lbs 15 oz.
( ) 8 lbs - 9 lb 15 oz. ( ) 10 lbs - 11 lbs 15 oz. ( ) Unknown

16 - Any health complications following birth? ( ) Yes ( ) No If yes, please specify: ____________________________

DEVELOPMENTAL FACTORS (continued)

C - POSTNATAL PERIOD AND INFANCY:

17 - Were there any early infancy feeding problems? ( ) Yes ( ) No
( ) Unknown

18 - Was the infant colicky? ( ) Yes ( ) No
( ) Unknown

19 - Were there early infancy sleep pattern difficulties? ( ) Yes ( ) No
( ) Unknown

20 - Was the infant alert and responsive? ( ) Yes ( ) No
( ) Unknown

21 - Did the child experience health problems during infancy? ( ) Yes ( ) No
( ) Unknown

22 - Did the child have any congenital abnormalities at birth? ( ) Yes ( ) No
( ) Unknown

23 - Was the child easy to care for? (cried very little, followed a schedule fairly well, etc..)
( ) Very Easy ( ) Easy ( ) Average ( ) Difficult ( ) Very Difficult

24 - How did the child behave with other people?

( ) Very Sociable ( ) Average ( ) Unsociable

25 - When the child wanted something, how insistent was (s)he?

( ) Very Insistent ( ) Pretty Insistent ( ) Average ( ) Not very insistent ( ) Not insistent at all

26 - How would you rate the activity level of the child as an infant/toddler?

( ) Very Active ( ) Active ( ) Average ( ) Less Active ( ) Inactive

D - DEVELOPMENTAL MILESTONES:

At what age did the child:

27 - Sit up? ( ) 1-3 months ( ) 4-7 months ( ) Over 8 months
( ) Unknown

28 - Crawl? ( ) 3-6 months ( ) 6-10 months ( ) Over 11 months
( ) Unknown

29 - Walk? ( ) 6-13 months ( ) 14-17 months ( ) Over 18 months
( ) Unknown
(not just stand)

30 - At what age did the child start speaking single words (other than mama and dada)?

( ) 6-8 months ( ) 9-10 months ( ) 10-14 months ( ) 15-24 months
( ) 25-36 months ( ) Over 37 months ( ) Unknown or not at all

31 - At what age did the child string two or more words together?

( ) 9-13 months ( ) 14-18 months ( ) 19-24 months ( ) 25-36 months
( ) 37-48 months ( ) Unknown or not at all

32 - At what age was the child toilet trained? (only bladder control)?

( ) Under 1 year ( ) 1-2 years ( ) 2-3 years ( ) 3-4 years ( ) Unknown

33 - At what age was the child completely toilet trained (bladder and bowel control)?

( ) Under 1 year ( ) 1-2 years ( ) 2-3 years ( ) 3-4 years ( ) Unknown

34 - Approximately how much time did toilet training take from onset to completion?

( ) Less than 1 month ( ) 1-2 months ( ) 2-3 months
( ) More than 3 months ( ) Unknown or not at all

II. MEDICAL HISTORY

35 - How would you describe the child's health?

( ) Very Good ( ) Good ( ) Fair ( ) Poor ( ) Very Poor

36 - How is the child's hearing?

( ) Good ( ) Fair ( ) Poor

37 - How is the child's vision?

( ) Good ( ) Fair ( ) Poor

38. - How is the child's gross motor coordination (e.g. walking, running, etc.)?

( ) Good ( ) Fair ( ) Poor

39. - How is the child's fine motor coordination (more detailed activities like drawing)?

( ) Good ( ) Fair ( ) Poor

40 - How is the child's speech articulation (ability to clearly pronounce the letters in words)?

( ) Good ( ) Fair ( ) Poor

41 - Has the child had any chronic health problems (e.g. asthma, diabetes, heart condition)?

( ) No ( ) Yes ( ) If yes, please specify: ______________

42 - When was the onset of any chronic illness?

( ) Birth ( ) 0-1 years ( ) 1-2 years ( ) 2-3 years
( ) 3-4 years ( ) Over 4 years ( ) Not applicable

43 - Which of the following illnesses has the child had? (check all that are applicable)

( ) Mumps ( ) Measles ( ) Encephalitis ( ) Otitis Media
( ) Seizures ( ) Chicken Pox ( ) Scarlet fever ( ) Whooping Cough
( ) Pneumonia ( ) Lead Poisoning ( ) Other disease: ______________

44 - Has the child had any accidents resulting in the following?

( ) Broken Bones ( ) Eye Injury ( ) Head Injury (with loss of consciousness)
( ) Severe bruises ( ) Sutures ( ) Head Injury (w/o loss of consciousness and no concussion)
( ) Stomach Pumped ( ) Lost teeth ( ) Severe Lacerations
( ) Other: ______________

45 - How many accidents (such as the ones state above) has the child had?

( ) One -1 ( ) 2-3 ( ) 4-7 ( ) 8-12 ( ) Over 12

46 - Has the child ever had surgery for any of the following conditions?

( ) Tonsilitis ( ) Adenoids ( ) Eye, ear, nose & throat ( ) Hernia
( ) Appendicitis ( ) Digestive Disorder ( ) Urinary Tract ( ) Leg or arm
( ) Burns ( ) Other disease: ______________

47 - How many times has the child had surgery for the above stated conditions?

( ) Once ( ) Twice ( ) 3-5 times ( ) 6-8 times ( ) Over 8 times

48 - Duration of hospitalization?

( ) One day ( ) Overnight ( ) 2-3 days ( ) 4-6 days
( ) 1-4 weeks ( ) 1-2 months ( ) Over 2 months

49 - Is there any suspicion of your child using drugs or alcohol?

( ) No ( ) Yes ( ) Don't know

50 - Is there any history of physical/sexual abuse?

( ) No ( ) Yes ( ) Don't know
( ) Any suspicion of this, and if so why do you suspect it: ______________

51 - Does the child have any problems sleeping?

( ) Difficulty falling asleep ( ) Early morning awakening
( ) Sleep continuity disturbance ( ) None

52 - Is the child a restless sleeper?

( ) No ( ) Yes ( ) Don't know

53 - Does the child have bladder control problems at night?

( ) No ( ) Yes ( ) If yes, how often? ________________

54 - Does the child have bladder control problems during the day?

( ) No ( ) Yes ( ) If yes, how often? ________________

55 - Does the child have bowel control problems at night?

( ) No ( ) Yes ( ) If yes, how often? ________________

56 - Does the child have bowel control problems during the day?

( ) No ( ) Yes ( ) If yes, how often? ________________

57 - Does the child have any appetite control problems?

( ) Overeats ( ) Average ( ) Under eats

III. TREATMENT HISTORY

58 - Has the child ever been prescribed any of the following?

MEDICATION	HOW MANY MONTHS USED
( ) Ritalin (or Methylphenidate or Focalin)	________________
( ) Tranquilizers	________________
( ) Dexedrine (or Adderall)	________________
( ) Cylert	________________
( ) Anticonvulsants (Tegratol, Lamictal, Depakote)	________________
( ) Antihistamines	________________
( ) Other Prescription drugs	________________
Please specify:	________________

59 - Has the child ever had any of the following forms of treatment?

TREATMENT	HOW LONG DID IT LAST?	WHERE AND WHO PROVIDED?
( ) Individual Psychotherapy	________________	________________
( ) Group Psychotherapy	________________	________________
( ) Family therapy w/child	________________	________________
( ) Inpatient evaluation	________________	________________
( ) Residential treatment	________________	________________

IV. SCHOOL HISTORY

Please summarize the child's progress (e.g. academic, social, testing) within each grade level.

Preschool:

Kindergarten

Grades 1-3

Grades 4-6

Grades 7 - 12

60 - Has the child ever been in a special educational program?

PROGRAM	HOW LONG DID IT LAST?
( ) Learning disabilities class	________
( ) Behavioral/emotional disorders class	________
( ) Resource room	________
( ) Speech and language therapy	________
( ) Occupational or physical therapy	________

61 - Has the child ever been:

( ) Suspended from school Number of times: ________
( ) Expelled from school Number of times: ________
( ) Retained in grade Number of times: ________

62 - Have any additional school modifications been attempted:

( ) None ( ) Daily/weekly report card
( ) Behavior modification program ( ) Other (please specify) ________

V. SOCIAL HISTORY

63 - How does the child get along with their siblings"?

( ) Doesn't have any ( ) Average ( ) Better than average ( ) Worse than average

64 - How easily does the child make friends?

( ) Easier than average ( ) Average ( ) Worse than average ( ) Don't Know

65 - On average, how long does the child maintain friendships?

( ) Less than 6 months ( ) 6 months - 1 year ( ) More than 1 year ( ) Don't Know

IV. CURRENT BEHAVIORAL CONCERNS

Primary Concerns:

____

____

Other concerns: ______________________________
(related)

____

66 - What strategies have been implemented to address these problems? Check which have been successful.

( ) Verbal reprimands ( ) Time outs (isolation) ( ) Removal of privileges
( ) Rewards ( ) Physical punishment ( ) Avoidance of child ( ) Giving into child

67 - On average, what percentage of the time does the child comply with initial requests?

( ) 0 - 20% ( ) 20 - 40% ( ) 40 - 60% ( ) 60 - 80% ( ) 80 - 100%

68 - On average, what percentage of the time does the child eventually comply with requests?

( ) 0 - 20% ( ) 20 - 40% ( ) 40 - 60% ( ) 60 - 80% ( ) 80 - 100%

69 - To what extent are you and your partner (if you have one) consistent with respect to disciplinary strategies?

( ) Most of the time ( ) Some of the time ( ) None of the time ( ) Single parent

70 - Have any of the following stress events occurred within the past 12 months?

( ) Parent divorced or separated ( ) Family accident or illness ( ) Death in family
( ) Parent changed job ( ) Changed schools ( ) Family moved
( ) Family financial problems ( ) Other (please specify)________________

71 - Which do you consider to be a significant problem for the child at the present time?

( ) Fidgets ( ) Shifts from one activity to another ( ) Difficulty remaining seated
( ) Difficulty playing quietly ( ) Easily distracted ( ) Often talks excessively
( ) Difficulty following instructions ( ) Interrupts or intrudes on others
( ) Difficulty sustaining attention ( ) Often does not listen
( ) Blurts our answers to questions before they have been completed
( ) Often loses things ( ) Often loses engages in physically dangerous activities

72 - When did these problems begin? (Specify age) ____________

73 - Which are considered to be a significant problem for the child at the present time?

( ) Often loses temper ( ) Often blames others for own behaviors
( ) Often argues with adults ( ) Is often touchy or easily annoyed by others
( ) Is often angry or resentful ( ) Often actively defies or refuses adult requests or rules
( ) Is often spiteful or vindictive ( ) Often deliberately does things that annoy other people
( ) Often uses obscene language

74 - When did these problems begin? (Specify age) ____________

75 - Which are considered to be a significant problem for the child at the present time?

( ) Stolen without confrontation
( ) Cruel to animals
( ) Lies often
( ) Used a weapon in a fight
( ) Often initiates physical fights
( ) Stolen with confrontation
( ) Physically cruel to people
( ) Destroyed others' property
( ) Runaway from home overnight at least twice
( ) Forced someone else into sexual situation
( ) Deliberate fire setting
( ) Often truant
( ) Breaking and entering

76 - When did these problems begin? (Specify age) ____________

77 - Which are considered to be a significant problem for the child at the present time?

( ) Unrealistic and persistent worry about possible harm to attachment figures
( ) Persistent avoidance of being alone ( ) Repeated nightmares re: separation
( ) Unrealistic and persistent worry that a calamitous event will separate the child from the attachment figure
( ) Excessive distress in anticipation of separation from attachment figures
( ) Persistent school refusal ( ) Excessive distress when separated from home or attachment figures ( ) Persistent refusal to sleep alone

78 - When did these problems begin? (Specify age) ____________

79 - Which are considered to be a significant problem for the child at the present time?

( ) Unrealistic worry about future events ( ) Unrealistic concern about competence
( ) Somatic complaints ( ) Unrealistic concern re: appropriateness of past behaviors
( ) Excessive need for reassurance ( ) Marked inability to relax
( ) Marked self-consciousness

80 - When did these problems begin? (Specify age) ____________

81 - Which are considered to be a significant problem for the child at the present time?

( ) Depressed or irritable mood most of the day, nearly every day
( ) Psychomotor agitation/retardation
( ) Fatigue or loss of energy ( ) Diminished pleasure in activities
( ) Feelings of worthlessness or excessive, inappropriate guilt
( ) Decrease or increase in appetite
( ) Diminished ability to concentrate associated w/possible failure to make weight gain
( ) Suicidal ideation or attempt ( ) Too little or too much sleep nearly every day

82 - When did these problems begin? (Specify age) ____________

83 - Which are considered to be a significant problem for the child at the present time?

( ) Depressed or irritable mood most of the day for one year
( ) Poor concentration or difficulty making decisions
( ) Feelings of hopelessness
( ) Poor appetite or overeating ( ) Insomnia or hypersomnia
( ) Low energy or fatigue ( ) Never without these symptoms for more than 2 months
( ) Low self-esteem over a 1 yr period

84 - When did these problems begin? (Specify age) ____________

VII. OTHER CONCERNS

85 - Has the child exhibited any of the symptoms below?

( ) Repetitive movements ( ) Overreacts to touch
( ) Odd postures ( ) Compulsive rituals
( ) Excessive reaction to noise or fails to react to loud noises
( ) Repetitive noises

86 - Has the child exhibited any symptoms of thought disturbance, including:

( ) Loose thinking (e.g., can't stay on topic)
( ) Disoriented, confused, staring, spacey
( ) Bizarre ideas (e.g., odd fascinations, false beliefs, hearing or seeing things which are not there)
( ) Incoherent speech (mumbles)

87 - Has the child exhibited any symptoms of affective disturbance, including:

( ) Situationally inappropriate emotions ( ) Explosive temper with minimal provocation
( ) Rapid, pressured speech ( ) Angry or high/giddy mood w/o use of drugs or alcohol
( ) Excessive clinging, attachment, or dependence on adults
( ) Decreased need for sleep ( ) Overconfidence
( ) Unusual fears ( ) Strange aversions
( ) Hypersexuality ( ) Panic attacks
( ) High motor activity ( ) No emotional reaction to things

88 - Has the child exhibited any symptoms of social conduct disturbance, including:

( ) Little or no interest in same age children ( ) Excessive reaction to change in routine
( ) Significantly off topic speech ( ) Abnormalities of speech
( ) Initiates or terminates interactions inappropriately ( ) Self-stimulation activity (hand flicking, rocking, etc.) ( ) Abnormal social behavior

FAMILY HISTORY

Please list any (blood related) relatives who have any of the following:

Problem	How is this person related? (father, paternal uncle etc.)
Aggression, defiance, opposition	
Attention, hyperactivity, impulsive	
Learning disability	
Mental retardation	
Autism, Asperger's	
Schizophrenia (psychosis)	
Depression	
Anxiety (panic)	
Tourette's (tic) disorder	
Substance abuse (alcohol too)	
Antisocial behavior (assault, theft, arrests)	
Physical/sexual abuse	
Bipolar (manic-depressive) disorder	
"Nervous breakdown"	

NAME: ____________________ DATE: ____________________

Genitourinary:

____ Change in Color of Urine
____ Decreased Urination
____ Painful Urination
____ Frequent Urination at Night
____ Increased Urination
____ Erectile Dysfunction
____ Change in Menstrual Cycle

Skeletal:

____ Scoliosis
____ High Arched Feet

Neurological:

____ Loss of Smell
____ Loss of Taste
____ Double Vision
____ Dizziness
____ Falls
____ Balance Difficulty
____ Difficulty Chewing
____ Swallowing Problems
____ Excessive Eye Movement
____ Speech Problems
____ Decreased Facial Sensation
____ Loss of General Sensation
____ Generalized Weakness of Muscles
____ Sensation of Heavy Eyelids or Difficulty Holding Eyelids Open
____ Muscle Paralysis (Inability to Move Any Particular Muscle)

Please Describe: ____________________

____ Decrease in Muscle Size (Specify Where: ____________________)
____ Decrease in Muscle Strength (Specify Where: ____________________)
____ Involuntary Movement such as Shaking, Twitching or Spasms
____ Decreased or Increased Sense of Touch
____ Burning Pain
____ Numbness
____ Tingling
____ Headaches
____ Muscle Pain, Swelling or Tenderness (Specify Where: ____________________)
____ Easily Fatigued Muscles when Exercising
____ Muscle Cramps
____ Excessive Sweating

NAME: ______________________ DATE: ______________________

Neurological: (continued)

____ Inability to Control Urine or Bowels ____ Depression

____ Impotence ____ Loss of Early Morning Erections ____ Mood Swings

____ Memory Loss ____ Difficulty Concentrating ____Seizures

____ Blackouts ____ Uncontrollable or Inappropriate Crying or Laughing

____ Excessive Sleeping (Hyper Somnolence)

____ Inability to Sleep (Insomnia) ____ Fainting Spells

____ Lightheadedness

____ Lower Back Pain (Specify: With or Without Radiation to Legs? __________)

____ Neck Pain (Specify: With or Without Radiation to Arms? ______________)