Dr. Kracke & Associates, P.A.

NEW CLIENT INFORMATION SHEET (CHILD)

Therapist: _____ Appointment Date: _____ Appointment Time: _____ AM/PM

Patient Information

Patient Name: _____ Date of Birth: _____ Age: _____
Gender: _____ Social Security Number: _____-_____-_____
Parent/Guardian Name: _____ Relation to child: _____
Mailing Address: _____
Street Address: _____
Email: _____@_____ May we contact you by email? _____ (Initial _____)
Cell Phone: _____ (Detailed message? ____) Home Phone: _____ (Detailed message? ____)
School: _____ Grade: _____ Address: _____
Parent/Guardian Employer: _____ OK to contact? _____ Work Phone # _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Primary Care Physician: _____ Date of last visit: _____
PCP Address: _____ Phone: _____ Fax: _____
Do we have your permission to contact the physician listed above? _____ (Parent Initial _____/ Child Initial _____)
Please list ALL allergies: _____
Please provide all current Medications and Dosages (use separate sheet if needed): _____
_____
May we text you at the cell phone number provided? _____ (Initial _____)

Primary Insurance Policy Holder/Responsible Party

Full Name: _____ Date of Birth: _____ Relation to patient: _____
Social Security Number: _____-_____-_____ Email: _____@_____
Mailing Address: _____
Street Address: _____
Cell Phone: _____ (Detailed message? ____) Home Phone: _____ (Detailed message? ____)
Employer: _____ Address: _____ Phone: _____
Name of Primary Insurance: _____
Subscriber ID#: _____ Group#: _____ Effective Date: _____
Insurance Address: _____ Phone#: _____
Does the patient reside with the policy holder? _____ If not, where? _____

Secondary Insurance Policy Holder/Responsible Party

Full Name: _____ Date of Birth: _____ Relation to patient: _____
Social Security Number: _____-_____-_____ Email: _____@_____
Mailing Address: _____
Street Address: _____
Cell Phone: _____ (Detailed message? ____) Home Phone: _____ (Detailed message? ____)
Employer: _____ Address: _____ Phone: _____
Name of Secondary Insurance: _____
Subscriber ID#: _____ Group#: _____ Effective Date: _____
Insurance Address: _____ Phone#: _____
Please list ALL other existing insurance covering patient: _____

VERY IMPORTANT: If you are seeing another mental health provider (psychiatrist, counselor, etc.) and you are on a managed care plan, or you have had an evaluation done elsewhere, it is essential that we have that information to know how many visits and how often to request authorization for further sessions. Please list any other mental health care providers you have seen in the past 3 years below.

_____
_____
_____
_____

THE UNDERSIGNED HEREBY AUTHORIZES THE RELEASE OF ANY INFORMATION TO **ALL** OF MY INSURANCE COMPANY(IES) FOR CLAIMS SUBMITTED ON BEHALF OF ME AND/OR MY DEPENDENTS. I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE BELOW AUTHORIZES DR. KRACKE AND ASSOSICATES, P.A. TO SUBMIT CLAIM(S) FOR SERVICES RENDERED WITHOUT OBTAINING MY SIGNATURE ON ANY AND ALL CLAIM(S) SUBMITTED. ANY FAILURE TO DISCLOSE ADDITIONAL INSURANCE WILL RESULT IN OUR BILLING YOU FOR THE CHARGES.

I UNDERSTAND I AM THE PARTY RESPONSIBLE FOR ALL CHARGES FOR SERVICES - REGARDLESS OF INSURANCE COVERAGE AND AGREE TO ASSIGN ALL BENEFITS TO DR. KRACKE AND ASSOCIATES, P.A. AND/OR PAY FOR SERVICES FOR ME AND/OR ANY OF MY DEPENDENTS OR PERSONS LISTED AS PATIENT, REGARDLESS OF RELSTIONSHIP TO ME.

X _____ _____
Signature for Primary Insurance *Date*

X _____ _____
Signature for Secondary Insurance *Date*

X _____ _____
Signature of Child over 14 years of age *Date*

Please bring your photo ID and insurance cards and give to receptionist or therapist for copying. Thank-you!

Intake Information Form-Child/Adolescent

Parent's/ Guardian's Name: _____ Date: _____

Child's Name:_____ Date of Birth: _____ Age:_____
Please circle the individual completing this form is [circle one] (mother – father – grandparent – sibling - concerned family member or friend – other legal guardian) of the child.

In order to assist the therapist obtaining a thorough understanding of your child's current situation, please complete this intake packet by either filling in or circling items as appropriate.

Child's Information
My child has lived in _____ for about _____ (months-years).

Family History
The quality of our family relationship is (good – fair - poor).
Biological parents are (married – separated – divorced).
If divorced, father has _____% custody and mother has _____% custody.
My child has _____ siblings that live at the primary residence and _____ siblings that reside outside of the child's primary residence.

Education
My child is currently in the ____ (grade) at _____ (school).
His/Her overall progress is (below average – average - above average).
(When applicable): My child is enrolled in _____ special needs program.

Employment history
If child is an adolescent (12 to 18 years of age), have they ever been employed? Yes – No. If currently employed, he/she has worked at _____ for approximately _____ (months-years). If previously employed, worked at _____ for approximately _____ (months-years).

Health History
My child has significant medical difficulties with his/her (heart – stomach – cancer – pain - high blood pressure – diabetes - weight related issues – kidneys – lungs – allergies - or _____).
There (has been – has not been) a recent significant change in my child's (weight – appetite - sleep pattern).
My child has had major surgery for _____ on _____ (month/year).
My adolescent child (is – has previously been – has never been) pregnant.

Medication history
My child is currently taking the following medications _____
_____ for his/her medical condition.
For mental health issues, my child is taking _____ (medication) for _____(months-years) and the current dosage is _____. This medication has had (positive benefits - negative effects) as indicated by _____.
For mental health issues, my child is taking _____ (medication) for _____(months-years) and the current dosage is _____. This medication has had (positive benefits - negative effects) as indicated by _____.
For mental health issues, my child is taking _____ (medication) for _____(months-years) and the current dosage is _____. This medication has had (positive benefits - negative effects) as indicated by _____.

Abuse history
In the past my child (has been - has not been) a victim of abuse (physical – sexual – emotional - neglect) by his/her (mother – father - other family members – class mate - unknown stranger). This occurred to my child at the approximate age of ____ (years).

PLEASE CONTINUE TO PAGE 2

Current Mental Health Concerns

Presenting problem

My child's current mental health concern is _____. The severity of this current mental health concern is (mild – moderate – severe - disabling). Please list two observable symptoms of your child's current mental health concern, (for example: crying, poor appetite, intrusive thoughts) _____ and _____.

History of presenting problem

My child's current mental health concern has been in evidence for (weeks – months - years). I (have – have not) addressed my child's mental health concerns with other mental health professionals. If so, please list all previous mental health professionals who have seen my child _____ (use separate page if necessary). Previous treatment was obtained (in the last year - a number of years ago – I cannot remember how long ago). My child is currently receiving Psycho-Social Rehabilitation (PSR) Services (and – or) out-patient mental health treatment at _____.

Adequacy of Previous Treatment

My child's previous treatment, in my estimation proved to be (very - somewhat – only minimally – or not at all) effective. Explain: _____.

Baseline Measure

Using the following scale with 10 being high and zero being nothing, rank your child's level of the following: depression = ____, anxiety = _____, and irritability/anger = _____ , pain =_____.

Generally my child is (outgoing - stays to himself/herself - just like everyone else) when it comes to being sociable.

Psychiatric history (circle all those that apply)

My child has a history of: depression – anxiety - hearing things that others say aren't there - lots of thoughts coming at the same time - quick mood changes - poor appetite - sleep related difficulties - energy related difficulties - wishing they were dead - psychiatric hospitalizations - flashbacks of bad things that have happened to them - repetitive thoughts - compulsive behavior, phobias - unusual perceptual experiences - disturbances of consciousness – seizures - blackouts, amnesia - repetitive behaviors to do something or to check something - sexual dysfunction - anger related issues - violent behavior - attending difficulties – distractibility – impulsiveness - poor regulation of mood - &/or _____.

Family psychiatric history

Based on the biological mother's and biological father's family history, there appears to be (no – some) family history of mental health related issues. In my child's family history there appears to be a history of (depression – anxiety - alcohol abuse - other psychiatric disorders) in the following family members (mother – father – siblings – maternal grandparents – paternal grandparents).

Substance use

My child currently smokes cigarettes (yes - no)

My child currently (does – does not) use alcohol, (minimally – moderately - excessively).

Currently I suspect my child is using (alcohol - prescription medications – marijuana – uppers – downers – crank – crack - IV substances) on a (daily-weekly-monthly) basis.

Where applicable to adult completing this document:

I am currently (employed - unemployed). If employed I currently work at _____.

I have worked at this company for _____ (months), _____ (years).

I (graduated from high school/college – did not graduate from high school/college – earned a GED).

My overall success academically was (below average – average – above average).

I am currently (single, never married – married – separated - divorced). The quality of my relationship with my child's biological (mother – father) is generally (good – fair - poor).

I have been married (1 – 2 – 3+) times.

I have (no – 1 – 2 – 3 – 4+) children.

Thank you for taking the time to complete this medical background information.

Name: _____ Date: _____

Name of Parent: _____

PURPOSE: Have your child complete this questionnaire. Thank-you.
The YOQ.SR-2 is designed to describe a wide range of troublesome situations, behaviors, and moods that are common in children and adolescents. You may discover that some of the items do not apply to your current situation. If so, **please do not leave these items blank** but circle the "Never or almost never" category. When you begin to complete the YOQ.SR-2 you will see that you can easily make yourself look as healthy or unhealthy as you wish. Please do not do that. If you are as accurate as possible it is more likely that you will be able to receive the help that you are seeking.

DIRECTIONS:
- Read each statement carefully.
- Decide how true this statement is for you during the **past 7 days.**
- Circle the number that most accurately describes you **during the past week.**
- **Circle only one answer for each statement and erase unwanted marks clearly**.

PLEASE COMPLETE BOTH SIDES

0	1	2	3	4
Never or almost never true	**Rarely true**	**Sometimes true**	**Frequently true**	**Almost always or always true**

0 1 2 3 4 **1. I want to be alone more than others my age.**
0 1 2 3 4 **2. I have headaches or feel dizzy.**
0 1 2 3 4 **3. I don't participate in activities that used to be fun.**
0 1 2 3 4 **4. I argue or speak rudely to others.**
0 1 2 3 4 **5. Is more fearful than other children of the same age.**
0 1 2 3 4 **6. I cut classes or skip school altogether.**
0 1 2 3 4 **7. I cooperate with rules and expectations of adults.**
0 1 2 3 4 **8. I have a hard time finishing my assignments or I do them carelessly.**
0 1 2 3 4 **9. I complain about things that are unfair.**
0 1 2 3 4 **10. I have trouble with constipation or diarrhea.**
0 1 2 3 4 **11. I have physical fights (hitting, kicking, biting, or scratching) with family or others my age.**
0 1 2 3 4 **12. I worry and can't get thoughts out of my mind.**
0 1 2 3 4 **13. I steal or lie.**
0 1 2 3 4 **14. I have a hard time sitting still (or I have too much energy).**
0 1 2 3 4 **15. I feel anxious or nervous.**
0 1 2 3 4 **16. I talk with others in a friendly way.**
0 1 2 3 4 **17. I am tense and easily startled (jumpy).**
0 1 2 3 4 **18. I have trouble with wetting or messing my pants or bed.**
0 1 2 3 4 **19. I physically fight with adults.**
0 1 2 3 4 **20. I see, hear, or believe in things that are not real.**
0 1 2 3 4 **21. I have hurt myself on purpose (for example, cut, scratched, or attempted suicide).**
0 1 2 3 4 **22. I use alcohol or drugs.**
0 1 2 3 4 **23. I am disorganized (or I can't seem to get organized).**
0 1 2 3 4 **24. I enjoy my relationships with family and friends.**

PLEASE CONTINUE TO SECOND PAGE

0	1	2	3	4
Never or almost never true	Rarely true	Sometimes true	Frequently true	Almost always or always true

My Child:

0 1 2 3 4 **25. I am sad or unhappy**
0 1 2 3 4 **26. I have pain or weakness in muscles or joints.**
0 1 2 3 4 **27. I have a hard time trusting friends, family members, or other adults**
0 1 2 3 4 **28. I think that others are trying to hurt me even when they are not.**
0 1 2 3 4 **29. I have threatened to, or have run away from home.**
0 1 2 3 4 **30. My emotions are strong and change quickly**
0 1 2 3 4 **31. I break rules, laws, or don't meet others' expectations on purpose.**
0 1 2 3 4 **32. I am happy with myself.**
0 1 2 3 4 **33. I pout, cry, or feel sorry for myself more than others my age.**
0 1 2 3 4 **34. I withdraw from my family and friends.**
0 1 2 3 4 **35. My stomach hurts or I feel sick more than others my age.**
0 1 2 3 4 **36. I don't have friends or I don't keep friends very long..**
0 1 2 3 4 **37. My parents or guardians don't approve of my friends.**
0 1 2 3 4 **38. I think I can hear other people's thoughts or that they can hear mine**
0 1 2 3 4 **39. I am involved in sexual behavior that my friends or family would not approve of.**
0 1 2 3 4 **40. I have a hard time waiting for my turn in activities or conversations.**
0 1 2 3 4 **41. I think about suicide or I feel I would be better off dead.**
0 1 2 3 4 **42. I have nightmares, trouble getting to sleep, oversleeping, or waking up too early.**
0 1 2 3 4 **43. I complain about or question rules, expectations, or responsibilities.**
0 1 2 3 4 **44. I have times of unusual happiness or excessive energy.**
0 1 2 3 4 **45. I am generally okay with frustration or boredom.**
0 1 2 3 4 **46. I am afraid I'm going crazy.**
0 1 2 3 4 **47. I feel guilty when I do something wrong.**
0 1 2 3 4 **48. I demand a lot from others or I am pushy.**
0 1 2 3 4 **49. I feel irritated.**
0 1 2 3 4 **50. I throw up or I feel sick to my stomach more than others my age.**
0 1 2 3 4 **51. I get angry enough to threaten others.**
0 1 2 3 4 **52. I get into trouble when I am bored**
0 1 2 3 4 **53. I am hopeful and positive.**
0 1 2 3 4 **54. Muscles in my face, arms, or body twitch or jerk..**
0 1 2 3 4 **55. I destroyed property on purpose.**
0 1 2 3 4 **56. I have a hard time concentrating, thinking clearly, or sticking to tasks.**
0 1 2 3 4 **57. I get down to myself and blame myself for things that go wrong.**
0 1 2 3 4 **58. I have lost a lot of weight without being sick.**
0 1 2 3 4 **59. I act without thinking and don't worry about what will happen.**
0 1 2 3 4 **60. I am calm.**
0 1 2 3 4 **61. I don't forgive myself for things I have done wrong.**
0 1 2 3 4 **62. I don't have much energy.**
0 1 2 3 4 **63. I feel like I don't have any friends or that no one likes me.**
0 1 2 3 4 **64. I get frustrated or upset easily and give up.**

Guidelines for Clinical Interpretation

The YOQ®-2.0 total score quantifies overall level of disturbance. A score of 46 or higher is in the clinical or dysfunctional range. A score under 46 is considered to be in the normal or non-clinical range. The reliable change index for the YOQ®-2.0 is 13 points. This means that a patient must change by at least 13 points for that change to be considered clinically significant.

Child/Adolescent Clinical Assessment

Name of Child:_____ **Today's Date:**_____

Informant:_____**Relationship to Child:**_____

Referral by:_____

Reason for Referral:_ _____

_____

Parental Objectives:_____

_____

_____

_____

_____

_____

I. DEVELOPMENTAL FACTORS

A. Prenatal History

1. How was your health during pregnancy?

Good ____ (1)
Fair ____ (2)
Poor ____ (5)
Don't know ____

2. How old were you when your child was born?

Under 20 ____ (1)
20-24 ____ (2)
25-29 ____ (3)
30-34 ____ (4)
35-39 ____ (5)
40-44 ____ (6)
Over 44____ (7)
Don't know ____

Do you recall using any of the following substances or medications during pregnancy?

3. Beer or wine

(1) Never
(2) Once or twice
(3) 3-9 times
(4) 10-19 times
(5) 20-39 times
(6) 40+ times

4. Hard liquor

(1) Never
(2) Once or twice
(3) 3-9 times
(4) 10-19 times
(5) 20-39 times
(6) 40+ times

5. Coffee or other caffeine (Cokes, etc.)

(1) Never
(2) Once or twice
(3) 3-9 times
(4) 10-19 times
(5) 20-39 times
(6) 40+ times

6. Cigarettes

(1) Never
(2) Once or twice
(3) 3-9 times
(4) 10-19 times
(5) 20-39 times
(6) 40+ times

7. Did you ingest any of the following substances prior to pregnancy?

___ Valium (Litrium, Xanax)
___ Tranquilizers
___ Anti-seizure medications (e.g. Dilantin)
___ Treatment for diabetes
___ Antibiotics (for viral infections)
___ Sleeping pills
___ Other (please specify):_____

B. Perinatal History

8. Did you have toxemia or eclampsia?

No ____ (0)
Yes ____ (1)
Don't know____

9. Was there Rh factor incompatibility?

No ____ (0)
Yes ____ (1)
Don't know____

10. Was (s)he born on schedule?

8 mo. Or earlier____ (1)
Term 08-10 mo.____ (2)
10 mo.____ (3)
Don't know____

11. What was the duration of labor? Under 6 hours____ (1)

7-12 hours____ (2)
13-18 hour____ (3)
19-24 hours____ (4)
Over 24 hours____ (5)
Don't know____

12. Were you given any drugs to ease the pain during labor?

No____ (0)

Name of Drug:_____ **Yes____ (1)**

Don't know____

13. Were there indications of fetal distress during labor or during birth?

No____ (0)

Yes____ (1)

Don't know____

14. Was delivery

Normal? **No____ (0)** **Yes____ (1)**

Breech? **No____ (0)** **Yes____ (1)**

Caesarean? **No____ (0)** **Yes____ (1)**

Forceps? **No____ (0)** **Yes____ (1)**

Induced? **No____ (0)** **Yes____ (1)**

15. What was the child's birth weight?

2 lb.-3 lb. 15 oz.____ (1)
4 lb.-5 lb. 15 oz.____ (2)
6 lb.-7 lb. 15 oz.____ (3)
8 lb.-9 lb. 15 oz.____ (4)
10 lb.-11 lb. 15 oz.____ (5)
Don't know____

16. Were there any health complications following birth?

No____ (0)

If yes, specify: _____Yes____ (1)

C. Postnatal Period & Infancy

17. Were there early infancy feeding problems? **No____ (0)** **Yes____ (1)**

18. Was the child colicky? **No____ (0)** **Yes____ (1)**

19. Were there early infancy sleep pattern difficulties? **No____ (0)** **Yes____ (1)**

20. Were there problems with the infant's responsiveness (alertness)? **No____ (0)**

Yes____ (1)

21. Did the child experience any health problems during infancy? No____ (0)
Yes____ (1)

Did the child experience any high fevers during infancy? No____ (0)
Yes____ (1)

22. Did the child have any congenital problems? No____ (0)
Yes____ (1)

23. Was the child an easy baby? By that I mean did (s)he cry a lot? Did (s)he follow a schedule fairly well?
Very easy____ (0)
Easy____ (1)
Average____ (2)
Difficult____ (3)
Very difficult____ (4)

24. How did the baby behave with other people?
More sociable than average____ (1)
Average sociability____ (2)
More unsociable than average____ (3)

25. When (s)he wanted something, how insistent was (s)he?
Very insistent____ (0)
Pretty insistent ____ (1)
Average____ (2)
Not very insistent____ (4)
Not at all insistent____ (5)

26. How would you rate the activity level of the child?
Very active____ (1)
Active____ (2)
Average____ (3)
Less active____ (4)
Not active____ (5)

27. At what age did (s)he sit up?
3-6 mo.____ (1)
7-12 mo.____ (2)
Over 12 mo.____ (3)
Don't know____

28. At what age did (s)he crawl?
6-12 mo.____ (1)
13-18 mo.____ (2)
Over 12 mo.____ (3)

Don't know____

29. At what age did (s)he walk?

Under 1 yr.____ (1)
1-2 yr.____ (2)
2-3 yr.____ (3)
Don't know____

30. At what age did (s)he speak single words(other than "mama" or "dada")?

9-13 mo.____ (1)
14-18 mo.____ (2)
19-24 mo.____ (3)
25-36 mo.____ (4)
37-48 mo.____ (5)
Don't know____

31. At what age did (s)he string two or more words together?

9-13 mo.____ (1)
14-18 mo.____ (2)
19-24 mo.____ (3)
25-36 mo.____ (4)
37-48 mo.____ (5)
Don't know____

32. At what age was (s)he toilet-trained? (bladder control)?

Under 1 yr.____ (1)
1-2 yr.____ (2)
2-3 yr.____ (3)
3-4 yr.____ (4)
Don't know____

33. At what age was (s)he toilet-trained? (bowel control)?

Under 1 yr.____ (1)
1-2 yr.____ (2)
2-3 yr.____ (3)
3-4 yr.____ (4)
Don't know____

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

Less than 1 mo.____ (1)
1-2 mo.____ (2)
2-3 mo.____ (3)
More than 3 mos.____ (4)

II. MEDICAL HISTORY

35. How would you describe his/her health?

Very good____ (1)

Good____ (2)
Fair____ (3)
Poor____ (4)
Very poor____ (5)

36. How is his/her hearing?
Good____ (1)
Fair____ (2)
Poor____ (3)

37. How is his/her vision?
Good____ (1)
Fair____ (2)
Poor____ (3)

38. How is his/her gross motor coordination?
Good____ (1)
Fair____ (2)
Poor____ (3)

39. How is his/her fine motor coordination?
Good____ (1)
Fair____ (2)
Poor____ (3)

40. How is his/her speech articulation?
Good____ (1)
Fair____ (2)
Poor____ (3)

41. Has (s)he had any chronic health problems?(e.g., asthma, diabetes, heart condition)
No____ (0)
Yes____ (1)
If yes, please specify:_____

42. When was the onset of any chronic illness? (e.g., bladder control)
Birth____ (1)
0-1 yr____ (2)
1-2 yr____ (3)
2-3 yr____ (4)
3-4 yr____ (5)
over 4 yr.____

43. Which of the following illnesses has the child had? (For the following, Y/N)
Mumps ____
Whooping cough ____

Measles ____
Chicken pox ____
Scarlet fever ____
Pneumonia ____
Encephalitis ____
Otitis media ____
Lead poisoning ____
Seizures ____

Other diseases (specify):_____

44. Has the child had any accidents resulting in the following? (Y/N)

Broken bones ____
Severe lacerations ____
Head injury ____
Severe bruises ____
Stomach pumped ____
Eye injury ____
Lost teeth ____
Sutures ____

45. How many accidents?

One____ (1)
2-3____ (2)
4-7____ (3)
8-12____ (4)
Over 12____ (5)

46. Has (s)he ever had surgery for any of the following? (Y/N)

Tonsillitis ____
Adenoids ____
Hernia ____
Appendicitis ____
Eye, ear, nose, throat____
Digestive disorder ____
Urinary tract ____
Leg or arm ____
Burns ____
Other ____

47. How many times?

Once____(1)
Twice____(2)
3-5____(3)
6-8____(4)
Over 8____(5)

48. Duration of hospitalization?

One day____(1)
One day + one night____(2)
2-3 days____(3)

4-6 days____(4)
1-4 weeks____(5)
1-2 mo.____(6)
Over 2 months____(7)

49. Is there any suspicion of alcohol or drug use?

No____ (0)
Yes____ (1)
Don't know____

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

No____ (0)
Yes____ (1)
Don't know____

51. Does the child have any problems sleeping?

None____ (0)
Difficulty falling asleep____ (1)
Sleep continuity disturbance____ (2)
Early morning awakening____ (3)

52. Is the child a restless sleeper?

No____ (0)
Yes____ (1)
Don't know____

53. Does the child have bladder problems at night?

No____ (0)
Yes____ (1)
If yes, how often?_____
If yes, was (s)he ever continent at night?
No____ (0)
Yes____ (1)
If yes, how often?_____
If yes, was (s)he ever continent during the day?
No____ (0)
Yes____ (1)
If yes, how often?_____

54. Does the child have any appetite control problems?

Overeats____(1)
Average____(2)
Under eats____(3)

III. TREATMENT HISTORY

55. Has the child ever been prescribed any of the following? (Y/N)

Ritalin	_____	**Tranquilizers**	_____
Duration of use	_____	**Duration of use**	_____
Dexedrine	_____	**Anticonvulsant**	_____
Duration of use	_____	**Duration of use**	_____
Cylert	_____	**Antihistamines**	_____
Duration of use	_____	**Duration of use**	_____

Other prescription drugs_____
Duration of use_____

56. Has the child ever had any of the following forms of psychological treatment? If so, how long did it last? (0=No; 01=Yes)

Individual psychotherapy_____
Duration of therapy _____
Group psychotherapy_____
Duration of therapy _____
Family therapy with child ____
Duration of therapy _____
Inpatient evaluation/Rx_____
Duration of stay _____
Residential treatment_____
Duration of placement_____

IV. SCHOOL HISTORY

Please summarize the child's progress (e.g. academic, social, testing) within each of these grade levels:

Preschool:

Kindergarten:

Grades 1 through 3:

Grades 4 through 6:

Grades 7 through 12:

57. Has the child ever been in any type of special educational program, and if so, how long?

Learning disabilities class	_____
Duration of placement	_____

Resource room _____
Duration of placement _____
Speech/language therapy _____
Duration of therapy _____
Behavioral/emotional disorders class _____
Duration of placement _____
Other (specify) _____
Duration _____

58. Has the child ever been:

Suspended from school _____
Number of suspensions _____
Expelled from school _____
Number of expulsions _____
Retained in grade _____
Number of retentions _____

59. Have any addition instructional modifications been attempted?

None____ (0)
Daily/weekly report card____ (1)
Behavior modification program____ (2)

V. SOCIAL HISTORY

60. How does the child get along with his/her siblings?

Doesn't have any____(0)
Better than average____(1)
Average____(2)
Worse than average____(3)

61. How easily does the child make friends?

Easier than average____(1)
Average____(2)
Worse than average____(3)
Don't know ____

62. On the average, how long does your child keep friendships?

Less than 6 months____ (1)
6 months-1 year____ (2)
More than 1 year____ (3)
Don't know____ (4)

VI. CURRENT BEHAVIORAL CONCERNS

Please list your primary concerns about behavior and any other related ones: _____

_____

_____

63. What strategies have been implemented to address these problems? (Check those that have been successful)

Verbal reprimands____ (1)
Time out (isolation)____ (2)
Removal of privileges____ (3)
Rewards____ (4)
Physical punishment____ (5)
Acquiescence to child____ (6)
Avoidance of child____ (7)

64. On the average, what percentage of the time does your child comply with initial commands?

0-20%____(1)
20-40%____(2)
40-60%____(3)
60-80%____(4)
80-100%____(5)

65. On the average, what percentage of the time does your child eventually comply commands?

0-20%____(1)
20-40%____(2)
40-60%____(3)
60-80%____(4)
80-100%____(5)

66. To what extent are you and your spouse consistent with respect to disciplinary strategies?

Most of the time____(1)
Some of the time____(2)
None of the time____(3)

67. Have any of the following stress events occurred within the past 12 months?

Parents divorced or separated____(1)
Family accident or illness____(2)
Death in family____(3)
Parent changed jobs____(4)
Changed schools____(5)
Family moved____(6)
Family financial problems____(7)
Other (please specify)____(8)

VII. DIAGNOSTIC CRITERIA

68. Which of the following are considered to be a significant problem at the present? (Y/N)

Fidgets	____
Difficulty remaining seated	____
Easily distracted	____
Difficulty awaiting turn	____
Often blurts out answers to questions before they have been completed	____
Difficulty following instruction	____
Difficulty sustaining attention	____
Shifts from one activity to another	____
Difficulty playing quietly	____
Often talks excessively	____
Often interrupts or intrudes on others	____
Often does not listen	____
Often loses things	____
Often engages in physically dangerous activities	____

TOTAL FOR ADHD_____ (8 or more)

69. When did these problems begin? (specify age): _____

70. Which of the following are considered to be a significant problem at the present? (0=No; 1=Yes)

Often loses temper	____
Often argues with adults	____
Often actively defies or refuses adult requests or rules	____
Often deliberately does things that annoy other people	____
Often blames others for own mistakes	____
Is often touchy or easily annoyed by others	____
Is often angry or resentful	____

TOTAL FOR OPPOSITIONAL DEFIANT DISORDER _____ (5 or more)

71. When did these problems begin? (specify age): _____

72. Which of the following are considered to be a significant problem at the present? (Y/N)

Stolen without confrontation	____
Often lies	____

Has run away from home overnight at least twice? ____
Has deliberately set fires ____
Often truant ____
Breaking and entering ____
Destroyed others' property ____
Cruel to animals ____
Forced someone else into sexual activity ____
Used a weapon in a fight ____
Often initiates physical fights ____
Stolen with confrontation ____
Physically cruel to people ____

TOTAL FOR CONDUCT DISORDER_____ (3 or more)

73. When did these problems begin? (specify age): _____

74. Which of the following are considered to be a significant problem at the present time? (Y/N)

Unrealistic and persistent worry about possible harm to attachment figures ____
Unrealistic and persistent worry that a calamitous event will separate the child from attachment figures ____
Persistent school refusal ____
Persistent refusal to sleep alone ____
Persistent avoidance of being alone ____
Repeated nightmares regarding separation ____
Physical complaints ____
Excessive distress in anticipation of separation from home or attachment figures ____

TOTAL FOR SEPARATION ANXIETY DISORDER _____ (3 or more)

75. When did these problems begin? (specify age): _____

76. Which of the following are considered to be a significant problem at the present? (Y/N)

Unrealistic worry about future events ____
Physical complaints ____
Unrealistic concerns about appropriateness of past behaviors ____
Marked self-consciousness ____
Excessive need for reassurance ____
Unrealistic concern about competence ____
TOTAL FOR OVERANXIOUS DISORDER _____ (4 or more)

77. When did these problems begin? (specify age): _____

78. Which of the following are considered to be a significant problem at the present? (0=No; 1=Yes)

Depressed or irritable mood most of the day nearly every day	____
Diminished pleasure in activities	____
Decrease or increase in appetite associated with possible failure to gain weight	____
Fatigue or loss of energy	____
Feelings of worthlessness or excessive inappropriate guilt	____
Sleeping too much or too little nearly every day	____
Diminished ability to concentrate	____
Talking about or attempting suicide	____
Moving about restlessly or moving around too little	____

TOTAL FOR MAJOR DEPRESSIVE DISORDER(items 3-9)____(5 or more)

79. When did these problems begin? (specify age) _____

80. Which of the following are considered to be a significant problem at the present? (Y/N)

Depressed or irritable mood most of the day for several months	____
Decrease or increase in appetite	____
Fatigue or loss of energy	____
Feelings of hopelessness	____
Sleeping too much or too little nearly every day	____
Poor concentration or difficulty making decisions	____
Never without symptoms for more than 2 months for over a year	____
Low self-esteem	____

TOTAL FOR DYSTHYMIA (items 2-7) _____(2 or more)

81. When did these problems begin? (specify age) _____

VIII. OTHER CONCERNS

82. Does the child consistently exhibit any of these symptoms? (Y/N)

Vocal tics	____
Odd postures	____
Overreacts to touch	____
Excessive reaction to noise or fails to react to loud noises	____
Compulsive rituals	____
Motor tics	____
TOTAL	_____

Other (please explain): _____
_____

83. Has the child consistently exhibited any symptoms of thought disturbance, including: (Y/N)

Bizarre ideas (e.g. delusions fascinations, hallucinations	____
Incoherent speech (mumbling or using jargon)	____
Being disoriented, confused, "spacey," staring	____
Loose thinking (e.g. difficulty expressing himself either by talking incessantly about unrelated issues or talking "around" a subject instead of addressing the topic)	____
TOTAL	_____

84. Has the child exhibited any symptoms of affective disturbance, including: (Y/N)

Explosive temper with little provocation	____
Excessive clinging, attachment or dependence on adults	____
Unusual fears	____
Strange aversions	____
Panic attacks	____
Excessively constricted or bland affect(no emotion)	____
Emotions inappropriate to the situation	____
Excessive mood changes inappropriate to the environment	____
TOTAL	_____

85. Has the child exhibited any symptoms of social conduct disturbance, including: (Y/N)

Little or no interest in peers	____

Significantly indiscreet remarks	**____**
Initiates or terminates interactions inappropriately	**____**
Self-mutilation	**____**
Excessive reaction to changes in routine	**____**
Abnormalities of speech	**____**
Reacts inappropriately in social situations	**____**
TOTAL	**_____**

86. How long have you and the child's father/mother been married? (Please note whether the child is from the 1st marriage, 2nd, etc.)

Never were married ____ (0)
Separated ____ (1)
Divorced ____ (2)
Widowed ____ (3)
Married for____ years ____ (4)

87. How stable is your <u>current</u> marriage? **Stable ____ (1)**
Unstable ____ (2)

THIS SHEET IS ABOUT THE <u>PATIENT'S FATHER</u> (paternal relatives):

0=No; 1=Yes

Father's Siblings

	Father	Father's Father	Father's Mother	Bro	Bro	Sis	Sis	Total
Problems with aggressive, defiance, & oppositional behavior as a child.								
Problems with attention, activity, & impulse control as a child.								
Learning disabilities.								

Failed to graduate from high school.								
Mental retardation.								
Psychosis or schizophrenia								
Depression for more than 2 weeks.								
Anxiety disorder that impaired adjustment.								
Tics or Tourette's								
Alcohol abuse								
Substance abuse								
Antisocial behavior (assaults, thefts, etc.)								
Arrests								
Physical abuse								
Sexual abuse								
Periods of Euphoria, excitability, decrease need for sleep or mania								

THIS SHEET IS ABOUT THE <u>PATIENT'S MOTHER</u> (maternal relatives):

0=No; 1=Yes

Mother's Siblings

	Mother	Mother's Father	Mother's Mother	Bro	Bro	Sis	Sis	Total
Problems with aggressive, defiance, & oppositional behavior as a child.								
Problems with attention, activity, & impulse control as a child.								
Learning disabilities.								
Failed to graduate from high school.								
Mental retardation.								
Psychosis or schizophrenia								
Depression for more than 2 weeks.								
Anxiety disorder that impaired adjustment.								
Tics or Tourette's								
Alcohol abuse								

Substance abuse								
Antisocial behavior (assaults, thefts, etc.)								
Arrests								
Physical abuse								
Sexual abuse								
Periods of Euphoria, excitability, decrease need for sleep or mania								

THIS SHEET IS ABOUT THE <u>PATIENT'S SIBLINGS</u>:

0=No; 1=Yes

	Patient's Brother	Patient's Brother	Patient's Sister	Patient's Sister	Total
Problems with aggressiveness, defiance, & oppositional behavior as a child.					
Problems with attention, activity, & impulse control as a child.					
Learning disabilities.					
Failed to graduate from high school.					
Mental retardation.					
Psychosis or schizophrenia					
Depression for more than 2 weeks.					
Anxiety disorder that impaired adjustment.					
Tics or Tourette's					
Alcohol abuse					
Substance abuse					
Antisocial behavior (assaults, thefts, etc.)					
Arrests					
Physical abuse					
Sexual abuse					
Periods of Euphoria, excitability, decrease need for sleep or mania					

Maternal Distress Scale

On the lines below are events or situations that may have occurred prior, during your pregnancy or following deliver. Please circle the item for the child that is being evaluated at Dr. Kracke & Associates, P.A.

Parent's Name:_____
Child's Name being evaluated:_____
Todays Date:_____

MPS Item
The number of pregnancies prior
None
1
2
3
4
Vaginal bleeding during pregnancy
1 none
2 some near end of pregnancy
3 some at beginning of pregnancy
4 a good deal throughout
Type of anesthesia
1 anesthesia injected into the spine
2 inhaled general anesthesia
3 injected general anesthesia
4 local anesthetic
5 none
Child's weight at birth
1 less than 3lbs.
2 3lbs., 1 oz. to 4lbs.
3 4lbs., 1 oz. to 5lbs.
4 5lbs., 1 oz. to 6lbs.
5 more than 6lbs.
Maternal Stress
1 very little
2 moderate amount
3 a good deal throughout
Child born after how many months
1 6
2 7
3 8
4 9
5 greater than 9 months
6 not sure
Length of labor
1 1-2 hours
2 3-5 hours
3 6-10 hours
4 11-16 hours
5 more than 16 hours

Maternal weight gain
1 less than 10 lbs.
2 11-15 lbs.
3 16-25 lbs.
4 26-35 lbs.
5 36-45 lbs.
6 in excess of 46 lbs.

Mother's age
1 under 15 years
2 15-19 years
3 20-29 years
4 30-34 years
5 35-39 years
6 over 40 years

Prenatal care obtained
1 months 1-3
2 months 4-6
3 months 7-8
4 after 8th month

Maternal swelling
1 minimal
2 some near the end of pregnancy
3 some near the beginning of pregnancy
4 a good deal throughout

Labor induced
1 no
2 yes --prior to the ninth month
3 yes --after ninth month

Forceps used
1 no forceps were necessary
2 yes, forceps were used 1
3 not sure, birth was cesarean
4 not sure

Planned pregnancy
1 carefully planned for
2 not planned but pleased
3 not planned & unhappy w/news
4 unplanned and unmarried

Multiple pregnancy
1 yes --twins
2 yes --triplets or more
3 no

Medication taken during pregnancy
1 prescribed vitamins and/or iron
2 drugs to reduce tension
3 water loss medication
4 aspirin on at least a weekly basis
5 other
6 no medication was taken

Presentation of the baby
1 feet first presentation (breech birth)
2 head first presentation
3 side presentation
4 no reason to believe different

Time between water break/labor
1 medication needed to induce labor
2 contractions began prior or at the time
3 began naturally < two hours
4 began naturally > two hours
5 not sure

Color of child after birth
1 yes, some blue
2 no

Gynecological surgery prior
1 surgery necessary to correct infertility
2 surgery necessary during pregnancy
3 prior therapeutic abortion
4 prior voluntary abortion
5 surgery necessary 2 years + prior
6 episiotomy for previous baby
7 no history of surgery

Prior pregnancies
1 none
2 one+ full term stillbirth or neonatal death
3 one or more resulting in normal birth
4 one + spontaneous abort/(miscarriage)

Cigarette use during pregnancy
1 none
2 1 to 10
3 11 to 20
4 21 to 30
5 more than 30

Average alcohol per day
1 none
2 1 to 2 drinks
3 3 to 4 drinks
4 more than 5 drinks

Maternal high blood pressure
1 Blood pressure was normal
2 Blood pressure was high at end
3 Had high bp, weight gain, swelling,
4 Was told preeclampsia, hospitalized

Rh incompatibility
1 No "Rh problems" were reported
2 This was 2+ child born Rh problems.
3 I was hospitalized / took medication
4 Child have anemia following birth.

Thank You