**CLINICAL HISTORY QUESTIONNAIRE**

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Person Completing Questionnaire: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

This questionnaire will permit the practitioner to gather relevant information regarding your child’s clinical information. While space is provided to include comments, please feel free to use additional paper to expand your thoughts. Thank you for your responses. The material on this form will remain strictly confidential.

## DEMOGRAPHIC INFORMATION

Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date of birth: Age: \_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent Telephone Number: (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name: Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name: Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Others living in the home/relationship/age:

child’s School/College: Grade/Year:\_\_\_\_\_\_\_\_\_\_

Physician’s Name: Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ pharmacy zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Evaluation**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## PATIENT’S MEDICAL HISTORY

Please describe your child’s present health:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any current medications (including vitamins or herbal remedies) and doses:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List any allergies to medications:

List any chronic medical conditions:

## FAMILY MEDICAL HISTORY

Please describe briefly any previous history of mental health issues or learning difficulties with family members.

 Parents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Siblings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Mother’s Family:

 Father’s Family:

**PAST PSYCHIATRIC HISTORY**

Is your child currently receiving counseling or therapeutic services? Yes \_\_\_\_ No \_\_\_\_

Has your child received counseling or therapeutic services in the past? Yes \_\_\_\_\_ No \_\_\_\_

 If yes to either question: Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Has it been beneficial? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of therapist(s)/time and duration seen:

Has your child ever required other treatment (inpatient, day treatment, etc.)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any previous psychotropic medication trials (dose, timeframe, prescriber):

Has your child ever had psychoeducational testing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**DEVELOPMENTAL HISTORY**

Please explain any complications during:

 Pregnancy:

 Labor: Delivery:

Was your child’s general health good at birth? Yes\_\_\_\_\_ No\_\_\_\_\_\_

 If no, please explain:

Did your child get onto a good sleeping and eating schedule as a baby?

Please describe your child’s gross-motor development (sitting, crawling, walking):

 Slow:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Normal:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Advanced:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your child’s fine-motor development (buttoning clothing, tying shoelaces,

holding a pencil, cutting with a scissors, writing):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your child’s speech/language development:

Were there any problems with toilet training? Yes\_\_\_\_\_ No\_\_\_\_\_ If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MARITAL AND FAMILY HISTORY**

Parent’s Marital Status: Married\_\_\_\_\_\_ Separated\_\_\_\_\_ Divorced\_\_\_\_\_\_ Remarried\_\_\_\_\_\_

 If parents are separated or divorced, for how long?

Is either parent remarried? Yes\_\_\_ No\_\_\_ If yes, which parent and for how long? \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the custody arrangements?

How long has the family lived in the current home?

**CHILD’S EDUCATIONAL HISTORY** (Please provide additional comments, as necessary, on the back of this sheet.)

***Nursery School***

School Name: Age of Entry:\_\_\_\_\_ Years Attended:\_\_\_\_\_\_\_\_\_\_\_

***Kindergarten***

School Name: Age of Entry:\_\_\_\_\_ Years Attended:\_\_\_\_\_\_\_\_\_\_\_

***Elementary School***

School Name(s): Age of Entry:\_\_\_\_\_ Years Attended:\_\_\_\_\_\_\_\_\_\_\_

***Middle School***

School Name(s): Age of Entry: \_\_\_\_ Years Attended:\_\_\_\_\_\_\_\_\_\_

# **High School**

School Name(s): Age of Entry: Years Attended: \_\_\_\_\_\_\_\_\_\_

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Please note any specific areas of concern related to academic performance:\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever repeated a year of school? Yes\_\_\_\_\_ No\_\_\_\_\_\_

 If yes, what grade(s)? Reason: \_\_\_\_\_

In general, how would you describe your child’s progress in school?

 Consistent\_\_\_\_\_\_ Uneven\_\_\_\_\_\_

 If uneven, please describe:

 Please note those areas in which your child experiences strengths:

 Please note those areas in which your child experiences weaknesses:

Do you feel that your child is achieving to his/her ability? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

 If no, please explain:

**SOCIAL HISTORY**

What leisure time activities does your child engage in (i.e., sports, art, music, collections, computer, television, reading, etc.)?

Does he/she relate comfortably to others? Yes\_\_\_\_\_ No\_\_\_\_\_\_ Comment:

Is he/she overly sensitive in friendships? Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximately how many friends does your child have?

 Do they seek him/her out? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

 Does he/she seek them out? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

 Are they: The same age\_\_\_ Older\_\_\_ Younger\_\_\_ Same Sex\_\_\_ Opposite Sex\_\_\_ Both\_\_\_

How does your child typically react to new experiences?

Anxiously\_\_\_ With Pleasure\_\_\_\_\_ Eagerly\_\_\_\_\_

What issues frustrate your child?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does your child react to frustration?

## MOOD SYMPTOMS

Describe your child’s general mood (happy, sad, irritable, bored):

Thoughts of death, suicide?

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Thoughts of harm towards others? Describe.

Hallucinations, delusions (hearing voices, seeing visions, unusual beliefs)?

Self-mutilation? Describe.

## ANXIETY SYMPTOMS

Would you describe your child as “anxious” or a “worrier?” Explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## SENSORY/OCCUPATIONAL THERAPY ISSUES

Has your child ever undergone an Occupational Therapy evaluation or treatment? Times and dates:

Check off any areas of difficulty: Comments

 Sensitivity to touch \_\_\_\_\_\_

 Sensitivity to sound \_\_\_\_\_\_

 Sensitivity to smell \_\_\_\_\_\_

 Sensitivity to taste \_\_\_\_\_\_

 Calmed by deep pressure \_\_\_\_\_\_

 Calmed by twirling \_\_\_\_\_\_

 Calmed by swinging \_\_\_\_\_\_

 “Flapping” or “Stimming” behavior \_\_\_\_\_\_

## ATTENTIONAL ISSUES

Would you describe your child as being: Overly active \_\_\_ Normally active \_\_\_ Sluggish \_\_\_\_

Is your child easily distracted? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

Do you notice that your child daydreams? Yes\_\_\_\_ No\_\_\_\_ If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can your child be impulsive (do things without thinking them all the way through)?

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your child’s judgment? \_\_\_\_\_\_\_\_\_\_\_\_

**On the back of this page, please include any additional information you feel would be helpful. Thank you for completing this questionnaire.**

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