Julie Evans Bingham, Ph.D. — Licensed Clinical Psychologist
Richard Bingham, M.D. — Board Certified Psychiatrist

BACKGROUND QUESTIONNAIRE

Please take a moment to read and fill out the following questions. The information that you provide is an important step in the psychological evaluation process and allows me to better serve you and your child.

FAMILY DATA

Child's name: ______________________________ Today's date: ______________
Birthdate: ______________________________ Age: ________ Sex (circle one) Male Female
County of residence: ______________________________
School: ______________________________ Grade: __________ Teacher: ______________
Person filling out this form (circle one): Mother Father Stepmother Stepfather Grandparent
Other (please explain): ______________________________

Parents are currently: ____ Married ____ Divorced ____ Remarried ____ Never married
Child's custodian/guardian (Name) ______________________ Relation to child: ______________
If parents are divorced, please describe custody/visitation arrangement: ______________________________
____
____

Mother's name: ______________________ Birthdate: ______________ Home phone: ________
Address (if different from child): ______________________________
Currently employed: ____ No ____ Yes, as: ______________________ Work phone: ________

Father's name: ______________________ Birthdate: ______________ Home phone: ________
Address (if different from child): ______________________________
Currently employed: ____ No ____ Yes, as: ______________________ Work phone: ________

Stepparent's name: ______________________ Birthdate: ______________ Home phone: ________
Address (if different from child): ______________________________
Currently employed: ____ No ____ Yes, as: ______________________ Work phone: ________

List all people currently living in household:

Name	Relationship to Child	Age

If any brothers or sisters are living outside the home, list their names and ages: ______________________________
____
____
____

PSYCHIATRIC FAMILY GENETIC HISTORY QUESTIONNAIRE

BACKGROUND: As a group, psychiatric disorders (or emotional and behavioral problems in kids) have a relatively high heritability. This means that genetics is a major factor in the development of these problems and illnesses. A careful assessment of the family history of these problems is quite helpful in diagnosis and treatment planning. With the human genome project now completed and ever more information available about genetics, this family history information is becoming increasingly important. A family history of problems suggests the presence of genetic risk. Remember, genetic risk increases the probability of developing a similar or related problem, but genes are not destiny. Many other factors (including we hope, early recognition and treatment) play an important role in whether a problem will develop and at what level of severity.

GENERAL DIRECTIONS: This is a lengthy and somewhat complicated questionnaire, but please hang in there and take it step by step since it is quite important. For a genetic history we are considering "blood relatives" (not the foster or adoptive family). You can greatly increase how accurate and complete this information is by making sure to follow these proven principles:

a) get information from more than one family member on both the mother's and father's sides
b) first identify all close relatives by name and age
c) take time to carefully consider each and every close relative for each kind of problem, and
d) include whatever information you have

An adult patient will typically complete this history themselves, consulting members from both sides of their family. For a child, the parent will complete it. The parent most familiar with that side of the family history should complete the information (i.e., this might mean the mother would complete the mother's side, and the father the father's side, unless the mother is the family member who actually knows more for both sides, or if only one parent is available) Read all the directions for Step A, and then complete it. Next, read all the items for Step B and complete it. Take a quick look now at the accompanying "Recording Form" you will use to record the information.

STEP A: Listing ALL the close relatives (simpler than it looks).

1. Write in who completed the **mother's side** history (e.g., Mom-Julie), and circle yes or no regarding whether other family members were consulted (hopefully yes!).
2. Write the patient's mother's first name and age (for parents completing this form, remember, this is *not your mother*, but the child's) For age, if the person is 20 or older, simply write the decade of life (e.g., 40s), if younger than 20, then write your best estimate of the age.
3. Then write the first names of the patient's grandmother and grandfather and their ages (again, for parents or guardians of the patient, this is *not your grandmother*).
4. If someone is deceased, write the age at which they had died (e.g., 50s), and draw a light diagonal line through the age.
5. Next write down **all** maternal (mother's blood relatives) aunts and uncles first names (do not include half aunts/uncles).
6. Write down **all** brothers and sisters (listed as "siblings"). Include half-siblings, and put ½ after the word "sibling". For siblings, indicate if they are male (m) or female (f) after their age (e.g., 14f). Your child's siblings need not be duplicated in the mother's and father's list, but half siblings would appear on one side or the other. If the patient has children, these can be listed in the "Other" section or on the back.
7. Now repeat all the above steps for the patient's **father's side** (again, for parents of the patient completing this form, make sure to *list relatives based on their relationship to the patient/child*).

Step B: Listing the family history.

1. Carefully read through the list of problems on the next page.
2. Have a conversation with one or two members on the mother's side of the family to gather information.
3. Start at the top with the mother's side (the patient's mother) and systematically go through each person. Think about all you know about this person, and then deliberately go through each item on the problem list to consider whether each of the problems is present in that person's history.
4. Each time the problem is present, indicate that by writing the "code" (the bold face letters) on the line following the person's age. Write as many problems as are present (e.g., hosp. suid. diag. med. drug).
5. On the full line below the family member's name, write additional details or information (e.g., hosp. in 20s. bipolar. suicide attempt. lithium. marijuana). Use the back of the paper to add more details if available.
6. Now repeat these steps with the father's side.
7. Celebrate, you've finished! Keep a copy for yourself.

<u>Problem List</u>

(Please remember to consider <u>each</u> of these questions for <u>each</u> of the close relatives)

1. Has this relative ever been **hosp**italized for psychiatric or substance abuse problems?
2. Has this relative ever made **suic**idal statements or had suicidal behavior?
3. Has this relative ever had clearly bizarre/**psych**otic behavior or thinking, hallucinations, or very strange untrue beliefs (delusions)?
4. Has this relative ever been treated with **med**ications for a psychiatric or emotional/behavioral problem (e.g., medicine for depression, anxiety, or hallucinations)? If known, write the name of the medicine.
5. Has this relative ever had a **diag**nosis for a psychiatric or emotional/behavioral problem? This would include problems such as depression, mania, bipolar disorder, anxiety, ADHD/hyperactivity, schizophrenia, tic disorders, panic disorder, enuresis, etc.
6. Has this relative ever had persistent moodiness or rapid emotional or mood **swings** that caused very serious problems?
7. Has this relative ever had **crim**inal behavior involving the police or courts (include if this was in the juvenile justice system)?
8. Has this relative ever had an **alco**hol abuse problem?
9. Has this relative ever had a **drug** abuse problem?
10. Has this relative ever had problems with recurrent **agg**ression, violence, or serious explosive anger?
11. Has this relative ever had problems with **learn**ing or a learning disorder (e.g., reading disorder or dyslexia)?
12. Has this relative ever had problems with a **devel**opmental disorder (e.g., mental retardation or autism-like problems)?
13. Has this relative ever had problems with a known **gene**tic disorder that runs in the family?

Family Genetic History Recording Form

Patient's First and Last Name, Age, and Gender: ______________________________

MOTHER'S Side: Completed by: ____________________ Consulted others: Yes or No

Relationship to Child	First Name	Age	History
Mother	__________	___	__________
Grandmother	__________	___	__________
Grandfather	__________	___	__________
Aunt/Uncle	__________	___	__________
Aunt/Uncle	__________	___	__________
Aunt/Uncle	__________	___	__________
Oldest Child/Sibling	__________	___	__________
Next Child/Sibling	__________	___	__________
Next Child/Sibling	__________	___	__________
Other: ________	__________	___	__________

FATHER'S Side: Completed by ____________________ Consulted Others: Yes or No

Relationship to Child	First Name	Age	History
Father	__________	___	__________
Grandmother	__________	___	__________
Grandfather	__________	___	__________
Aunt/Uncle	__________	___	__________
Aunt/Uncle	__________	___	__________
Aunt/Uncle	__________	___	__________
Oldest Child/Sibling	__________	___	__________
Next Child/Sibling	__________	___	__________
Next Child/Sibling	__________	___	__________
Other: ________	__________	___	__________

DEVELOPMENTAL HISTORY

Please fill in any of the information you have on the areas listed below.

During pregnancy, was mother on medications Yes ____ No ____
If yes, what kind? ____________________

During pregnancy, did mother smoke? Yes ____ No ____
If yes, how many cigarettes each day? ____________________

During pregnancy, did mother drink alcoholic beverages? Yes ____ No ____
If yes, what did she drink? ____________________
Approximately how much alcohol was consumed each day? ____________________

During pregnancy, did mother use drugs? Yes ____ No ____
If yes, what kind? ____________________

Was the child premature? Yes ____ No ____
If so, by how many months? ____________ Weight and height at birth? ____________

Any birth complications or problems? Yes ____ No ____
If yes, please describe: ____________________
____

Were there any feeding problems? Yes ____ No ____
If yes, please describe: ____________________
____

Were there any sleeping problems? Yes ____ No ____
If yes, please describe: ____________________
____

The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age, but have some idea, write the age followed by a question mark. If you do not know or do not remember the age at which the behavior occurred, please write a question mark.

Behavior	Age	Behavior	Age
Showed response to mother	___	Put several words together	___
Rolled over	___	Dressed self	___
Sat alone	___	Became toilet trained	___
Crawled	___	Stayed dry at night	___
Walked alone	___	Fed self	___
Babbled	___	Rode tricycle	___
Spoke first word	___		

Were there any other problems in the growth and development of the child during the first few years?
____
____
____
____

SOCIAL, PEER, AND EDUCATIONAL HISTORY

Place a check mark next to any behavior or problems you child currently exhibits.

___ Inability to make/keep friends
___ Little or no interest in peer relationships
___ Prefers younger or older children
___ Aggressive toward other children
___ Does not get along well with siblings
___ Seems more interested in things (e.g., objects, games, computer) than in people
___ Is shy or timid

___ Frequently disobeys adults
___ Aggressive toward adults
___ Disruptive in classroom
___ Does not get along well with teachers
___ Frequently removed from classroom for behavior problems
___ Refused to go to school

___ Has difficulty with reading
___ Has difficulty with arithmetic
___ Has difficulty with spelling
___ Has difficulty with writing

___ Has difficulty with other subjects (please list)
____
____
____

___ Has an identified learning disability (if yes, please describe):
____
____

___ Is in a special education class (If yes, please describe):
____
____

___ Has been held back in a grade (if yes, what grade and why):
____
____

___ Has received special tutoring or counseling in school (if yes, please describe):
____
____

GENERAL MEDICAL HISTORY

How is your child's general health currently? Excellent ☐ Good ☐ Fair ☐ Poor ☐ Explain: __________
____

Have there been concerns about growth or weight? No ☐ Yes ☐ Explain: ______________
____

Any problems with vision or hearing? No ☐ Yes ☐ Explain: ______________
____

Any serious chronic illnesses now or in the past? No ☐ Yes ☐ Explain: ______________
____

Please list any overnight hospitalizations (with reasons and age)? ______________
____

Any surgeries (for what and at what age); any continuing related problems? No ☐ Yes ☐ Explain: ___
____

Serious injuries? No ☐ Yes ☐ Explain: ______________________________

Allergies to medicine or serious allergies? No ☐ Yes ☐ Explain: ______________________________

When was the last complete physician examination: Month/year: ____________ Were there any problems identified? No ☐ Yes ☐ Explain: ______________________________

Any special dietary requirements? No ☐ Yes ☐ Explain: ______________________________

Immunizations up to date? No ☐ Yes ☐ Explain: ______________________________

Has your child had any of the following (please give details):

head injuries: No ☐ Yes ☐ Explain: ______________________________

episodes of loss of consciousness: No ☐ Yes ☐ Explain: ______________________________

current problems with sleep: No ☐ Yes ☐ Explain: ______________________________

seizures: No ☐ Yes ☐ Explain: ______________________________

recurrent headaches: No ☐ Yes ☐ Explain: ______________________________

abnormal movements, tics, or tremors: No ☐ Yes ☐ Explain: ______________________________

change in sensation: No ☐ Yes ☐ Explain: ______________________________

change in movement, coordination, or walking: No ☐ Yes ☐ Explain: ______________________________

change in speech: No ☐ Yes ☐ Explain: ______________________________

recurrent ear infections: No ☐ Yes ☐ Explain: ______________________________

changes in weight or concern about eating problems or disorders (e.g., anorexia) : No ☐ Yes ☐
Explain: ______________________________

persistent fatigue or fevers: No ☐ Yes ☐ Explain: ______________________________

skin changes: No ☐ Yes ☐ Explain: ______________________________

breathing or lung problems: No ☐ Yes ☐ Explain: ______________________________

heart or blood pressure problems: No ☐ Yes ☐ Explain: ______________________________

fainting or irregular heart beat: No ☐ Yes ☐ Explain: ______________________________

urination problems or wetting (enuresis): No ☐ Yes ☐ Explain: ______________________________

bowel problems or soiling (encopresis): No ☐ Yes ☐ Explain: ______________________

____

liver injury, infection, or other problems: No ☐ Yes ☐ Explain: ______________________

____

recurrent nausea, vomiting, or diarrhea: No ☐ Yes ☐ Explain: ______________________

____

delays or advances in onset of puberty: No ☐ Yes ☐ Explain: ______________________

____

menstrual problems or sexually transmitted infections: No ☐ Yes ☐ Explain: ______________________

____

kidney injury, infections, or other problems: No ☐ Yes ☐ Explain: ______________________

____

problems with bones, muscles, or joints, including recurrent pain: No ☐ Yes ☐ Explain: __________

____

other: No ☐ Yes ☐ Explain: ______________________

____

Is your child taking herbals, dietary supplements, and/or vitamins No ☐ Yes ☐
Please list the supplements and amount taken: ______________________

____

Is your child taking any regular medications (include nonprescription)? No ☐ Yes ☐

Please list the medication and current dose: ______________________

____

____

____