Benson Psychological Services, PC
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New Child Patient Questionnaire

All information submitted by you will be for professional use only.

Today's Date: _____

Child's name: _____
Date of Birth: _____ Age: _____
Sex: M F

Mother's name: _____
Mother's address: _____
Mother's phone: Home _____ Work _____ Cell _____
Father's name: _____
Father's address (if different): _____
Father's phone: Home _____ Work _____ Cell _____

Chief Concern:

Who suggested your child be seen for assessment? _____
What concerns do you have about your child and when did they begin?
_____
_____
_____
What has made them better/worse? _____
_____

Check the box that best describes your child's behavior over the past 6 months. ***If your child is currently taking medication, please rate your child's behavior when NOT on medication.***	**Past**	**Current**	**Never**
Fails to give close attention to detail or makes careless mistakes (e.g. homework)			
Has difficulty attending to what needs to be done/distractible			
Does not seem to listen when spoken to directly			
Does not follow through when given directions			

Check the box that best describes your child's behavior over the past 6 months.	**Past**	**Current**	**Never**
Has difficulties organizing tasks and activities			
Avoids, dislikes or does not want to start tasks			
Loses things necessary for tasks or activities (school assignments, pencils, books)			
Is easily distracted by noises or other things			
Is forgetful in daily activities			
Fidgets with hands or feet or squirms in seat			
Leaves seat when he/she is supposed to stay seated			
Runs about or climbs too much when he/she is supposed to stay in seat			
Has difficulty playing or starting quiet games			
Is "on the go" or acts as if "driven by a motor"			
Reckless/impulsive behavior (does things without thinking)			
Talks too much			
Blurts out answers before questions have been completed			
Has difficulty waiting his/her turn			
Interrupts or bothers others when they are talking or playing games			
Argues with adults			
Loses temper			
Actively disobeys or refuses to follow adult's request or rules			
Bothers people on purpose			
Blames others for his/her mistakes or misbehaviors			
Is touchy or easily annoyed by others			
Is angry or bitter			
Is hateful and wants to get even			
Bullies, threatens or scares others			
Starts physical fights			
Lies to get out of trouble or to avoid jobs (i.e. "cons" others)			
Skips school without permission			
Is physically unkind to people			
Has stolen things that have value			
Destroys others' property on purpose			
Is physically mean to animals			
Has set fires on purpose to cause damage			
Has broken into someone else's home, business or car			
Has stayed out all night without permission or run away from home overnight			
Has used a weapon that can cause serious physical harm (e.g. bat, broken bottle, brick)			

Check the box that best describes your child's behavior over the past 6 months.	**Past**	**Current**	**Never**
Is fearful, anxious or worried			
Feels useless or inferior			
Is afraid to try new things or meet new people, holds back or is afraid of making mistakes			
Blames self for problems, feels at fault			
Feels lonely, unwanted or unloved; complains that "no one loves me"			
Is sad or unhappy			
Feels different and easily embarrassed			
Is overly concerned about health/body			
Is loud			
Is stubborn or strong-willed			
Is forceful or emotionally overwhelming			
Is rigid or "gets stuck"			
Has problems getting along with you			
Has problems getting along with others his/her own age, making/keeping friends			
Has problems getting along with his/her siblings			
Has problems in group activities such as games or team play			
Decreased interest or pleasure in all or almost all activities of the day			
Has said things like "I wish I were dead" or has tried to hurt self			
Recurrent excessive distress when separated from home or caretakers			
Has distinct periods of usually irritable or unusually cheerful mood (different from normal)			
Has prolong temper tantrums (great than 20-30 minutes)			
Hears voices others do not hear			
Has compulsions (e.g. seems driven to wash hands, count, erase until holes appear)			
Has obsessions (e.g. persistent or repetitive thoughts: germs, doors left unlocked, etc)			
Has recurrent thoughts or dreams of a traumatic event			
Seems to avoid or have phobias of specific people, animals, things or situations			
Seems unaware of others' existence, is uninterested in interacting with others			
Obsessive interest in narrow or atypical topic or event (e.g. death, the supernatural, anatomy, fantasy characters)			
Appears uninterested in activities children his/her age usually like or participate in			
Has experimented with or abused drugs or alcohol			
Engages in repetitive or stereotypic behavior (e.g. shakes or flaps hands, repeatedly touches hair or other material)			

Check the box that best describes your child's behavior over the past 6 months.	**Past**	**Current**	**Never**
Has intense, narrow or unusual interests			
Has difficulty with transitions or change			
Notices if things are out of place or unexpected			
Sensitive to noise			
Sensitive to light			
Sensitive to touch			
Sensitive to taste or texture of food, or smells			
Sensitive to movement (spinning, swinging)			
Has unusual sensitivity or preference regarding clothing			

Developmental History

Birth:

Was child adopted? **Y/N** If yes, age at adoption _____. Is child aware of adoption? **Y/N**
Was the pregnancy planned? **Y/N**
Were there any problems during pregnancy? **Y/N** If yes, please list _____
_____
Type of delivery: Vaginal C-section (planned) Early On-time Late
At birth, any support needed (i.e., blue, NICU, jaundice, feeding)? **Y/N**
If yes, please list _____

Were any substances, medications or vitamins used by the mother prior to, during, or after pregnancy?

		Prior	**During**	**After**	**No**
Please indicate:	Beer/wine	_____	_____	_____	_____
	Other Alcohol	_____	_____	_____	_____
	Tobacco	_____	_____	_____	_____
	Marijuana	_____	_____	_____	_____
	Cocaine or Meth	_____	_____	_____	_____
	Prescription meds	_____	_____	_____	_____
	Over the counter	_____	_____	_____	_____
	Other:_____	_____	_____	_____	_____

Early Development:

Were developmental milestones (walking, talking, etc) met ___ Early ____ On time ____ Late
If late, give details: _____
Age entered daycare: _____
Age toilet trained: Day _____ Night _____

Behavioral concerns:
Would you describe your child as fussy/colicky as an infant? **Y/N**
Did your child have trouble sleeping as an infant (e.g. fidgety, erratic, hard to settle, overly sleepy)? **Y/N**
Did your child have many temper tantrums as a toddler? **Y/N**
Did you have trouble keeping a baby-sitter or daycare because of your child's behavior? **Y/N**

<u>Medical History</u>
Health Information:
Primary care provider: _____
Allergies: **Y/N** If yes, please list: _____
What major health issues/surgeries has your child had in the past?_____
_____
_____
What major health issues/surgeries does your child have currently?_____
_____
_____
Any concerns about sexuality? **Y/N**
Female: _____ Age at menarche.
Menstrual problems (heavy, cramps, irregular periods)? **Y/N**

Sleep problems:
Nightmares **Y/N**
Problems at bedtime (falling asleep, staying asleep) **Y/N** Explain _____
_____
Getting up in the morning **Y/N**
Snoring **Y/N**
Sleepwalking/talking **Y/N**
What is your child's bedtime: School nights _____ Weekends _____
When does your child wake up in the morning: School nights _____ Weekends _____

Please list any professionals (such as doctors, psychiatrists, psychologists, social workers, occupational therapists, speech therapists, physical therapists or alternative treatments) currently involved in your child's care: _____
_____
_____
_____

Current Medications:
What medication(s), including vitamins, herbal supplements or over the counter medications is your child currently taking?

Name	**Dose**
_____	_____
_____	_____
_____	_____

How have the psychiatric medications helped? _____
_____
_____

Past Medications:
List all psychiatric medications your child has taken in the past (Name/Dose/Age):

Name	**Dose**
_____	_____
_____	_____

School History:
School Name: _____ Current Grade: _____
Main Teacher or contact person: _____
Please describe your child's strongest areas in his/her schoolwork. _____
_____
Please describe your child's weakest areas in his/her schoolwork. _____
_____
Has your child ever repeated a grade or subject? **Y/N**
Does your child enjoy school? **Y/N**
Does your child get along with his/her teachers? **Y/N**
Other schools your child has attended: _____
_____

Has your child ever received any special education services (like a 504 Plan or IEP)? **Y/N**
Explain _____
Year started/ended _____
Are you satisfied with the services your child is receiving/has received? **Y/N**
Have any disciplinary actions been taken (detentions, suspension or expulsion)? **Y/N**
Explain _____
_____

Academically do you believe your child is average, below or above average? Please mark the appropriate box.

	Above Average		**Average**		**Problematic**
	1	**2**	**3**	**4**	**5**
Classroom assignment completion					
Homework completion					
Getting homework to and from school					
Organizational skills					
Reading, spelling, written expression					
Mathematics					
Other:					

Social History:

List your child's strengths, interests, activities _____

_____

_____

Please describe any major changes, trauma or stresses in your child's life (e.g., parents' relationship, family conflict, deaths, moves, change of school, birth of a brother/sister, death of a pet) and include how old your child was at the time. _____

_____

_____

_____

Are Legal or Social Services involved with your family?

___ Currently ___ In the Past ___ Never ___ Child ___ Other family member

Please describe: _____

_____

_____

Has your child experienced or seen any inappropriate sexual situations, domestic violence, physical or sexual abuse or other traumatic events? If yes, please specify and include how old your child was at the time. _____

_____

_____

_____

Are any major changes or stresses expected in the future? If yes, please specify.

_____
_____
_____
_____

Briefly describe important issues mother and father experienced growing up (e.g., family conflict, abuse, illness, death, frequent moves, etc.): _____
_____
_____
_____
_____
_____

Additional Information:

Please list everyone that currently lives at your child's household:

Name	Relationship to child	Age	Health Status	Education	Occupation

Please list everyone in 2nd household:

Name	Relationship to child	Age	Health Status	Education	Occupation

Religious Affiliation: _____

Pets in the household? _____

Family Medical and Psychiatric History:

Other	Maternal Aunt/Uncle	Paternal Aunt/Uncle	Maternal Grandparent	Paternal Grandparent	Sibling	Father	Mother	**__Biologic** **__Adoptive or other family** Please indicate if there is limited information about part of the family:
								Anxiety
								Depression/manic depression
								Suicide attempts
								Actual suicide
								Alcoholism/drug abuse (marijuana, meth, etc)
								Psychosis/Schizophrenia (hearing voices, seeing things)
								Paranoia/extreme suspiciousness/delusions
								Psychiatric Treatment:
								Counseling
								Medication
								Hospitalization
								Assaultive behavior
								Been in jail or prison
								Other severe behavior problems
								Sexual or other abuse
								Eating disorder (anorexia, bulimia, bingeing)
								Attention-deficit hyperactivity disorder (ADHD)/Attention-deficit Disorder (ADD)/Attention problems
								Learning/school problems/reading problems
								Dropped out before high school graduation
								Tics/facial movements/Tourette's
								Sleep problems
								Autism Spectrum disorders/Pervasive developmental disorder (PDD)/Asperger's
								Medical Issues