



BOSTON CHILDREN'S HOSPITAL DEPARTMENT OF PSYCHIATRY



CHILD & FAMILY HISTORY QUESTIONNAIRE

This questionnaire will give us important information that will help us understand your child and plan how to be most helpful to him or her. Please fill it out completely. If there are parts you don't understand, your clinician can help you at your first appointment. Thank you!

What is today's date?

What is the child's name?

What is the child's birthdate?

What is the child's sex?

What is your name?

What is your relationship to the child?

Biological Mother Biological Father Adoptive Mother Adoptive Father Foster Mother Foster Father

If other, please specify:

Are you the child's legal guardian? Yes No

If no, who is the child's legal guardian?

If the Department of Children and Families (DCF) is the legal guardian, please provide the following:

Caseworker Name:

Telephone:

CURRENT DIFFICULTIES

Please describe your child's difficulties that led you to request our services:

STRESSFUL EVENTS

Which of the following events has EVER happened to the child?

- Child's primary caregiver died
- Child experienced a long separation from his/her/their primary caregiver
- Child was exposed to domestic or community violence

- Child has been physically or sexually abused
- Child has been bullied or rejected by schoolmates
- Child has been in foster care
- Child has had court (judge or lawyer) involvement
- Child has witnessed frequent arguing between his/her/their parents or family members
- Child's parents have separated or divorced
- Child has been involved in custody or visitation disagreements
- Child's immediate family has had a change in its members
- Child's immediate family has had major financial difficulties
- Child's immediate family has had struggles with having enough food at home
- Child's immediate family has changed housing multiple times
- Child's immediate family member has had a serious medical problem
- Child's immediate family member has had mental illness
- Child's immediate family member has had substance abuse problems
- Child's immediate family member has been incarcerated
- Child has had a serious injury or illness
- Child has changed schools multiple times
- Child is stressed about his/her/their school performance
- Other (specify):
- None of the above

CURRENT BEHAVIORAL HEALTH TREATMENT

Which of the following behavioral health services is the child receiving NOW?

No current services

Psychiatric Medication

Name of clinic:

Name of prescriber:

Phone:

Name of Medication	Dose	Reason for Taking Medication	For How Long Has This Medication Been Taken?

Therapy

Name of agency:

Name of clinician:

Phone:

How often does child see the therapist?

For how long has the child been working with this therapist?

Other Services (specify):

PAST BEHAVIORAL HEALTH TREATMENT

Which of the following behavioral health services has the child received in the **PAST**?

No past services

Hospitalization on a psychiatric inpatient unit

When	Name of Hospital	For What Kind of Problem

Day Treatment Program (partial hospitalization)

When	Name of Program	For What Kind of Problem

Psychiatric Medication

Name of Medication	Dose	Reason for Taking Medication	For How Long Was This Medication Taken?	Reason for Stopping (if no longer taking)

Therapy

Name of Therapist	Agency	Reason for Therapy	How Long Did Therapy Last?	Reason for Stopping (if no longer participating)

Other Services (specify):

Has the child ever been evaluated for a behavioral health problem in a hospital emergency room or by a mobile crisis team?

No Yes If Yes, when?

Which of the following agencies has the child been involved with?

- Department of Children and Families
- Department of Youth Services
- None of the above
- Department of Mental Health
- Department of Developmental Services

MEDICAL

Which of the following medical problems has the child had, either NOW or in the PAST?

- Anemia
- Stomach or intestine problems (celiac, colitis)
- Head injury
- Headaches
- Liver problems (hepatitis)
- Thyroid problems
- Overweight
- Sexually transmitted diseases
- Trouble seeing
- Allergies (specify):
- Asthma
- Heart problems (chest pain, pounding heart, murmur)
- Diabetes
- Trouble hearing
- Blood cholesterol problems
- Brain infection (meningitis, encephalitis)
- Seizures
- Dizzy/fainting spells
- Kidney problems

Other (specify):

No medical problems

Does the child take medication for medical problems? Yes No

If yes, please specify:

When was the child's last complete physical exam?

To your knowledge, what were the results of the physical?

Normal Abnormal (describe):

Has the child been hospitalized for an illness, injury, or surgery? Yes No

If yes, please specify below:

WHEN	FOR WHAT KIND OF PROBLEM

BIRTH AND EARLY DEVELOPMENT

Which of the following problems did the child's birth mother have during her pregnancy with the child?

- Excessive vomiting
- Seizures
- High or low blood sugar
- Bleeding
- Injury to the abdomen
- Victim of violence
- Use of alcohol
- Use of street drugs (specify which):
- Use of medicine prescribed by a doctor (specify which):
- Anemia
- High blood pressure (toxemia)
- Infection
- X-rays to the abdomen
- Stress or depression
- Use of cigarettes

No pregnancy problems

I don't know

Which of the following problems did the child's birth mother or the child have during or after the child's birth?

Premature delivery

Low birthweight

Breech or forceps delivery

C-section

Infection in mother or child at delivery

Yellow jaundice

"Blue baby" (lack of oxygen at birth)

Birth injury or defects in child

Postpartum depression in the mother

Hospital intensive care for the child

Other (specify):

No labor/delivery problems

I don't know

When did the child reach each of the developmental milestones?

Crawled	Usual	Late	I don't know
Walked	Usual	Late	I don't know
Spoke words	Usual	Late	I don't know
Spoke sentences	Usual	Late	I don't know
Was toilet trained	Usual	Late	I don't know

1. Please select how often the child had the following difficulties when he/she/they was an infant or toddler

Slow to warm up to people:

Cried or was cranky or irritable:

Strong feelings when upset:

Trouble adapting to changes:

Stubborn:

Avoided new things, people, or experiences:

Irregular or difficult eating or sleeping:

Very active:

Difficulty staying focused when playing:

SCHOOL

What grade is the child in this year?

Ungraded classroom

What kind of placement does the child have this year?

Regular education 504 Plan Special education (has an IEP)

If the placement is special education, what is the child's disability?

Learning Emotional/Behavioral Autism Speech/Language

Other:

What are the child's usual grades?

Mostly A's or B's (4's) Mostly C's (3's) Mostly D's (2's) Mostly F's (1's)

Has the child ever repeated a grade? Yes No If Yes, which grade(s)?

Has the child ever been suspended or expelled? Yes No

If Yes, which grade(s) and what for?

Are there language or cultural issues that affect the child's school performance?

Yes No If Yes, please describe:

What special interests does the child enjoy?

Arts (music, dance, art, acting) Sports Technical (computer, robotics)

Literary (reading, writing) Other (specify):

How well does the child do with each of the following?

Attendance:	good	average	poor	Schoolwork:	good	average	poor
Homework:	good	average	poor	Classroom behavior:	good	average	poor
Friendships:	good	average	poor	Enjoyment of school:	good	average	poor

COMMUNITY ACTIVITIES

Which of the following community activities does the child regularly participate in?

- | | |
|---|--|
| <input type="checkbox"/> Summer Camp | <input type="checkbox"/> Afterschool Program |
| <input type="checkbox"/> Sports League | <input type="checkbox"/> Church, Temple or Mosque Activities |
| <input type="checkbox"/> Music, Art, or Dance Lessons | <input type="checkbox"/> Volunteer Activities |
| <input type="checkbox"/> Part-time Employment | <input type="checkbox"/> Other (specify): |

NUTRITION & HEALTH

Do you feel that the child has a healthy diet?

Yes No If No, Why not?

What time does the child fall asleep on school nights?

What time does the child wake up on school days?

On a typical day, how many hours does the child use video or computer games?

EXERCISE

In a typical week, how many times does the child engage in physical activity for at least 30 minutes?

1-2 times 3-4 times 5-6 times Every day

What are the child's usual types of exercise?

SOCIAL HISTORY

Married Separated or divorced

What is the current marital status of the child’s parents?

Partnered Never married

What is the child’s current living situation?

Widowed

Living with parent(s)/guardian(s)

Living with other family member(s)

Foster Care

Residential/group home

Department of Youth Services

Shelter

Other

If Other, please specify:

Please list all of the adults and children that live with the child right now:

Name	Age	Gender	Relationship to Child

What languages are spoken in the child’s home?

Which cultural group(s) does the child’s family identify with?

Which religion does the child’s family practice (if any)?

Please rate the child’s relationships with each of the following:

Parents: Close Distant Difficult

Siblings: Close Distant Difficult

Peers: Close Distant Difficult

CURRENT PARENTS

Mother (or 1st Parent):

How much schooling did Mother (or 1st Parent) finish?

Less than 8th grade 8th grade High School GED College Post-Graduate

What is Mother’s (or 1st Parent’s) occupation?

Full-time Part-time Currently unemployed

Father (or 2nd Parent):

How much schooling did Father (or 2nd Parent) finish?

Less than 8th grade 8th grade High School GED College Post-Graduate

What is Father's (or 2nd Parent's) occupation?

Full-time Part-time Currently unemployed

BIOLOGICAL PARENTS (if different from current parents)

Mother:

How much schooling did Mother finish?

Less than 8th grade 8th grade High School GED College Post-Graduate

What is Mother's occupation?

Full-time Part-time Currently unemployed

Father:

How much schooling did Father finish?

Less than 8th grade 8th grade High School GED College Post-Graduate

What is Father's occupation?

Full-time Part-time Currently unemployed

FAMILY HEALTH HISTORY

Which of the following health problems have the child's blood relatives suffered from?

<i>Health problems</i>	Mother	Father	Brother	Sister	Other
Attention-Deficit/Hyperactivity					
Anxiety					
Autism					
Bipolar					
Depression					
Developmental delay					
Diabetes					
Drug or alcohol abuse					
Heart disease					
High blood cholesterol					
Intellectual disability					

<i>Health problems (continued)</i>	Mother	Father	Brother	Sister	Other
Learning disability					
Obesity					
Obsessions/compulsive behavior					
Posttraumatic stress disorder					
Schizophrenia					
Seizures					
Suicide death					
Sudden death from heart attack before age 50					
Tics/Tourette's					
None of the above					

CHILD SYMPTOM MEASURE - PARENT/GUARDIAN REPORT*

Instructions *(to the parent or guardian of child)*: The questions below ask about things that might have bothered your child. For each question, check the box next to the number that best describes how much (or how often) your child has been bothered by each problem during the past TWO (2) WEEKS.

DO NOT COMPLETE THIS SECTION IF YOUR CHILD IS LESS THAN 6 YEARS OLD.

	During the past TWO (2) WEEKS , how much (or how often) has your child...	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Complained of stomachaches, headaches, or other aches and pains?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	2. Said he/she/they was worried about his/her/their health or about getting sick?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
II.	3. Had problems sleeping – that is, trouble falling asleep, staying asleep, or waking up too early?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
III.	4. Had problems paying attention when he/she/they was in class or doing his/her/their homework or reading a book or playing a game?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
IV.	5. Had less fun doing things than he/she/they used to?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	6. Seemed sad or depressed for several hours?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
V. & VI.	7. Seemed more irritated or easily annoyed than usual?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	8. Seemed angry or lost his/her/their temper?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
VII.	9. Started lots more projects than usual or did more risky things than usual?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	10. Slept less than usual for him/her/they, but still had lots of energy?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
VIII.	11. Said he/she/they felt nervous, anxious, or scared?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	12. Not been able to stop worrying?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
	13. Said he/she/they couldn't do things he/she/they wanted to or should have done, because they made him/her/they feel nervous?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
IX.	14.	Said he/she/they heard voices – when there was no one there – speaking about him/her/they or telling him/her/they what to do or saying bad things to him/her/they?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
	15.	Said that he/she/they has a vision when he/she/they was completely awake – that is, saw something or someone that no one else could see?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
X.	16.	Said that he/she/they had thoughts that kept coming into his/her/their mind that he/she/they would do something bad or that something bad would happen to him/her/they or to someone else?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
	17.	Said he/she/they felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
	18.	Seemed to worry a lot about things he/she/they touched being dirty or having germs or being poisoned?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
	19.	Said that he/she/they had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
In the past TWO (2) WEEKS , has your child...							
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know		
	21.	Smoked a cigarette, a cigar, or pipe, used snuff/chewing tobacco, or vaped nicotine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy or molly), hallucinogens (like LSD or shrooms), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know		

In the past **TWO (2) WEEKS**, has your child...

23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
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*Adapted from DSM-5 Parent/Guardian Level 1 Cross-Cutting Measure - Child Age 6-17
(Questions #24 and #25 assessed in diagnostic visit)

**THANK YOU FOR TAKING THE TIME TO
PROVIDE US WITH THIS IMPORTANT INFORMATION**