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CHILD CLINICAL INTERVIEW

Child's Name: _____ **Date:** _____
Address: _____
Phone: (Home) _____ (Cell) _____
Birth Date: _____ Age: _____ Sex: _____ Dominant Hand: _____
Birth Place: _____
School: _____ Grade: _____
Race: _____ Ethnic Identity: _____
Primary Language: _____ Secondary Language: _____
Physical Disabilities: _____
Current Living Situation: _____

Legal Guardian
Name: _____ Cell Phone: _____
Age: _____ Relationship to Child: _____ Occupation: _____
Legal Guardian
Name: _____ Cell Phone: _____
Age: _____ Relationship to Child: _____ Occupation: _____

PRESENTING SYMPTOMS (Why is your child here Today?)

_____
_____
_____
_____
_____
_____

FAMILY HISTORY

Answer the following questions with regards to your child's **biological** parents and siblings.

Mother
Education: _____ Occupation: _____
Learning Disorders: ___No ___Yes - Describe: _____
Health history: _____
Mental health history: _____
_____

Father
Education: _____ Occupation: _____
Learning Disorders: ___No ___Yes - Describe: _____
Health history: _____
Mental health history: _____
_____

Siblings
How many brothers and sisters does your child have? _____ Brothers _____ Sisters Childs birth order? _____
Do any brothers or sisters have physical, academic, or psychological problems? ___ No ___ Yes
Describe: _____
_____

NAME_____

Please check any of the following characteristics close biological family members had, and describe problem:

Condition	**Person and type/severity**	**Condition**	**Person and type/severity**
___ Epilepsy/seizures	_____	___ Alcoholism	_____
___ Learning disability	_____	___ Drug abuse of any kind	_____
___ Left-handedness	_____	___ Manic-depression (bipolar)	_____
___ Mental retardation	_____	___ Depression	_____
___ Alzheimer's disease	_____	___ Personality disorder	_____
___ Huntington's disease	_____	___ Schizophrenia	_____
___ Multiple sclerosis	_____	___ Other psychiatric disorder	_____
___ Parkinson's disease	_____	___ Speech or language disorder	_____
___ Other neurological disease	_____	___ Other major disease	_____

BIRTH DETAILS

On the following chart, please mark if any of the following apply for the period of time FROM CHILD'S CONCEPTION TO DELIVERY, and if so, how often. If you wish to add anything or make comments, please do so below the chart or in the comments section at the end of the questionnaire. (Please note that not everything on this list is a problem)

Did child's mother use/experience/ participate in ...	Never	1 to 3 times during conception or pregnancy	More than 3 times, but not with any regularity (such as once per month)*	Fairly Often	Almost Always	Always	Don't Know
Prenatal vitamins							
Birth control*							
Prescribed medications*							
Other drug or medication not prescribed*							
Alcohol (any amount or form)							
Smoking (herself or in proximity)							

**** Please specify below if this box is marked***

Comments or clarifications of the above: _____

_____

Any compilations during labor and delivery? NO or YES _____

_____

_____

Birth weight (if known) _____ Length (if known) _____

Did any of the following conditions impact your child during delivery or in the first few days afterwards?	YES	NO	DON'T KNOW	Comments
Injured during delivery				
Cardiopulmonary distress				
Delivered with cord around neck				
Had trouble breathing after delivery				
Needed oxygen				
Required being placed in an incubator				
Turned blue (was cyanotic)				
Turned yellow (was jaundiced)				
Had an infection				
Had seizures				
Was given medications for any purpose				
Born with a congenital birth defect				
Hospitalized for more than 7 days				

NAME_____

EARLY INFANCY

As an infant, was your child	YES	NO	Comments
Difficult to feed			
Difficult to get to sleep			
Colicky			
Easy to comfort			
Difficult to put on a schedule			
Difficult to keep busy			
Alert			
Cheerful			
Affectionate			
Sociable			
Overly active			
Stubborn, challenging			
Easy going			

CHILDHOOD AND ADOLESCENT BEHAVIOR AND DEVELOPMENT

At what about what age did your child:

Crawl_____Walk_____Talk_____ Toilet Trained_____

Were you ever told that your child had any developmental delay? NO YES

please elaborate: _____

_____

Before age seven, would you describe your child as:

1. Shy	YES	NO	5. High strung	YES	NO
2. Quiet	YES	NO	6. Overly active	YES	NO
3. Withdrawn	YES	NO	7. Clumsy	YES	NO
4. Anxious	YES	NO	8. Messy	YES	NO

Before the age of seven would you think that others would say that your child:

1. Don't pay attention to details	YES	NO	10. Fidget	YES	NO
2. Don't pay attention as long as needed	YES	NO	11. Have trouble sitting still	YES	NO
3. Don't seem to listen	YES	NO	12. Run around all the time	YES	NO
4. Don't finish things	YES	NO	13. Have trouble playing quietly	YES	NO
5. Can't organize things	YES	NO	14. Talk a lot	YES	NO
6. Avoid things that take a lot of effort	YES	NO	15. Blurt out answers to questions	YES	NO
7. Lose things	YES	NO	16. Have trouble waiting your turn	YES	NO
8. Are easily distracted	YES	NO	17. Interrupt others	YES	NO
9. Forget things	YES	NO	18. Don't mind your own business	YES	NO

Would you describe your child as, generally:

1. Not doing what adults request	YES	NO	4. Being an very shy	YES	NO
2. Acting like a bully	YES	NO	5. Being an very outgoing	YES	NO
3. Being excessively emotional	YES	NO			

Do you think that your child is:

1. Were down or depressed?	YES	NO	How long did this last?_____
2. Needed to do several things in a ritualistic way?	YES	NO	How long did this last?_____
3. Worried excessively about many things?	YES	NO	How long did this last?_____
4. Had a bladder accidents?	YES	NO	How many times?_____
5. Had bowel accidents?	YES	NO	How many times?_____
6. Were cruel to animals?	YES	NO	How many times?_____
7. Set fires when not asked?	YES	NO	How many times?_____
8. Were anxious when family rituals are disrupted?	YES	NO	How long did this last?_____
9. Had ideas that others thought were unusual?	YES	NO	How long did this last?_____
10. Avoided going to public places?	YES	NO	How long did this last?_____

NAME_____

11. Claimed to be ill before going to school?	YES	NO	How many times?_____
12. Had trouble getting thoughts out of your head?	YES	NO	How long did this last?_____
13. Had trouble falling asleep/staying asleep?	YES	NO	How many times?_____
14. Had fine motor problems?	YES	NO	How long did this last?_____
15. Unusual changes in appetite?	YES	NO	How long did this last?_____

Details of above if needed: _____

To the best of your knowledge, has your child ever been:

1. A victim of a violent crime?	YES	NO	4. Physically hurt by an adult?	YES	NO
2. A victim of any crime?	YES	NO	5. Sexually molested?	YES	NO
3. Been in a place where their life was at risk?	YES	NO	6. Traumatized in any way?	YES	NO

If so, please use the space below (or additional pages) to elaborate_____

_____

MEDICAL HISTORY

Date of last physical exam _____ Date next exam is scheduled_____

Has your child ever been diagnosed with:

1. Asthma	YES	NO	11. Broken bones	YES	NO
2. Allergies	YES	NO	12. Fevers over 104F	YES	NO
3. Diabetes	YES	NO	13. Heart or blood pressure problems	YES	NO
4. Arthritis	YES	NO	14. Head injury	YES	NO
5. Chronic illness	YES	NO	15. Loss of consciousness	YES	NO
6. Epilepsy/Seizures	YES	NO	16. Lead poisoning	YES	NO
7. Non-epileptic seizures	YES	NO	17. Surgery	YES	NO
8. HIV Infection/AIDS	YES	NO	18. Lengthy hospitalizations	YES	NO
9. Chicken Pox	YES	NO	19. Chronic ear infections	YES	NO
10. Hepatitis	YES	NO	20. Tropical Disease	YES	NO

Does your child have any other medical conditions not already marked above? YES NO

If you marked YES to any of the above please elaborate:_____

_____

Has your child ever had a mental health diagnosis?_____

Does your child currently have any mental health related symptoms?_____

_____

Describe the reasons and durations of all the hospitalizations your child has had:

1) _____
2) _____
3) _____
4) _____

Please describe ALL loss of consciousness, concussion, head injury or other head trauma:

1) _____
2) _____
3) _____
4) _____
5) _____

NAME_____

Has your child ever had prior psychological or neuropsychological evaluation? ___ No ___ Yes – If yes:
Date(s) of evaluation: _____
Reason(s) for evaluation: _____
Result(s) of evaluation: _____

What, if any, prescribed medication(s) does your child take on regular basis? (Use additional pages if needed)

Name of medication	How much (mg)	How often (Once per day, twice, three times)

Does your child participate in/use alternative medical treatments such as herbs, chiropractic etc? YES NO
If so, please specify which ones and condition(s) for which seek treatment:_____
_____

Has any parent, sibling or biological child been diagnosed with any mental health condition? YES NO

Relationship	Type of Problem	Any Treatment (Yes or No)	Type of Treatment	Comments

Has any other BIOLOGICAL relative been diagnosed with a mental health condition? YES NO

Relationship	Type of Problem	Any Treatment (Yes or No)	Type of Treatment	Comments

EDUCATION

Does your child have an IEP, or has your child ever diagnosed with a learning disorder, placed in a special education or pulled out of the regular classroom for special services? NO YES If YES, please elaborate:

_____
_____

Has your child ever been held back or advanced a grade?:_____
_____
_____

Has your child ever been suspended, expelled or otherwise had behavioral problems at school?:_____
_____
_____

Please list all formal schooling your child has had:

Ages	Grades	Name of School	Location	Public or Private?

NAME_____

SPORTS

Please list all sports activities participated in, starting with your earliest activity (from childhood to present).

Ages	Sport	Any injuries	Head trauma/loss of consciousness?

RECREATION and HOME LIFE

Briefly describe the kinds of things your child does for fun or recreation (games, TV, hobbies, books attending church, etc.):

_____
_____
_____
_____
_____
_____
_____

Briefly describe how Discipline is administered in the house (and who administers it):

_____
_____
_____
_____
_____
_____
_____

What would you most like to change about your child?:

_____
_____
_____
_____
_____
_____
_____

What do you enjoy most about your child?:

_____
_____
_____
_____
_____
_____
_____