Behavioral Diagnostics & Treatment

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Child & Family Information *(Parent to Complete)*

Today's Date: ____/____/____   Person Completing this Form: ________________________

Relationship to Patient: ___ Mother ___ Father ___ Step Mother ___ Step Father ___ Other _________________________________

Preferred Phone: ____-____-_____ Alternate Phone: ____-____-_____ Email: _______________________@____________________

Is it ok to include you in our database for occasional news or follow-up? ___Yes ___ No

If divorced, is the custody joint? ___Yes ___ No ___ N/A

If divorced, are you the custodial parent? ___Yes ___ No ___ N/A

If not, please list custodial parent name: ________________________________ Phone: ____-____-_____

Can you provide a copy of the custody order? ___Yes ___ No ___ N/A

Child/Teen Name: _______________________________ Birth Date: ____/____/____ (Age: ____)

Gender: ___ Male ___ Female

Address: ____ City: ____________________ State: _____ Zip: ___________

Child/Teen School:__________________________ Grade:_____ Teacher Name:________________________

Mailing Address: ____________________________________ City: ___________________ Zip: __________ Phone: ____-____-_____

Ethnic Background: ______________ Is Child Adopted? ____ Yes ____ No If yes, age at adoption: _______

Child's Religion:_________________ How often does child attend services? _____________________________

How many times have you moved since this child's birth? __________________

Referral Initiated by: ____

Main concerns about your child/teen: ____

What goals do you have for assessment or treatment?

1. ____   4. ____
2. ____   5. ____
3. ____   6. ____

Parent	**Name**	**Age**	**Occupation**	**Race**	**Education**	**Contact with Child**
Mother:	_____________________	____	______________	______________	________________	________________
Father:	_____________________	____	______________	______________	________________	________________
Stepmother:	_____________________	____	______________	______________	________________	________________
Stepfather:	_____________________	____	______________	______________	________________	________________

Other Children in Family: Name	**Age**	**Sex**	**Grade**	**How is School Going?**
______________________________	_____	______	_____	____
______________________________	_____	______	_____	____
______________________________	_____	______	_____	____
______________________________	_____	______	_____	____

Others Living in Household: Name **Age** **Sex** **Relationship to Patient**

______________________________ _____ ______ ____

______________________________ _____ ______ ____

Early Developmental History

Pregnancy & Child Birth

Did you have anything unusual happen during pregnancy? ____

Did you smoke, drink, or use drugs during your pregnancy? ____

If yes, please specify frequency, amount, name: ____

Labor and Delivery: Did anything unusual occur during labor or delivery? ____

Birth weight: _____________ Birth length: ______________ APGAR Score: __________

Infancy:

Was special care required as a newborn? ___Yes ___ No; If so, what? ____

Was your child re-admitted to the hospital in the first months? ___Yes ___ No; If so, when? __________ How long? _______________

What did you enjoy most about your child as an infant? ____

What was difficult about your child as an infant? ____

As an infant, was your child:

- Predictable? ___Yes ___ No; Provide details, if desired: ____
- Unpredictable? ___Yes ___ No; Provide details, if desired: ____
- Easy to parent? ___Yes ___ No; Provide details, if desired: ____
- A challenge to parent? ___Yes ___ No; Provide details, if desired: ____
- Further comments: ____

Developmental Milestones

Does your child show a hand preference? ___Yes ___ No; ___ Right ___ Left At what age?________

All developmental stages attained within normal limits? ___Yes ___ No

Sat unsupported at ____ months Bladder trained at ____ months

Bowel trained at ____ months Dry bed after ____ months

Walked unsupported at ____ months First words at ____months

Anything occur ages 0-3 years in child's life you thought might affect normal growth, development, or school success?

____

Health Care History

Physician/Pediatrician: ___________________________ Phone: ____-____-_____ ext. _____

Psychiatrist/Nurse Practitioner: ___________________________ Phone: ____-____-_____ ext. _____

Has your child taken daily medication for an extended period? ___ Yes ___ No *(If yes, list below)*

Is your child taking medication now? ___ Yes ___ No *(If yes, list below)*

Current Medications: Who prescribes the medication(s)? Dr._________________ Dr. _________________ Dr. _________________

___Adderall_____ mg ___ Adderall XR _____ mg ___ Concerta _____ mg

___Cylert _____ mg ___ Cymbalta _____ mg ___ Dexedrine_____ mg

___Effexor _____ mg ___ Focalin _____ mg ___ Intuniv _____ mg

___Prozac _____ mg ___ Ritalin _____ mg ___ Tenex _____ mg

___Vyvanse _____ mg ___ Wellbutrin _____ mg ___ Other _____ mg; List: ______________________________

Does your child have any problems sleeping now? ___ Yes ___ No ____

How many hours does your child sleep per night? ___ hours, on average

Does your child have a hard time getting up? ___ Yes ___ No ____

Does your child have any problems with eating? ___ Yes ___ No ____

Did your child have any problems in the past? ___ Yes ___ No ____

Previous Illnesses *(check all)*	**Year**	**Previous Illnesses**	**Year**
___ Meningitis	______	___ Hearing/vision problems	______
___ Encephalitis	______	___ Concussion/skull fracture	______
___ Recurrent earaches	______	___ Ingestion of poison	______
___ Recurrent respiratory	______	___ Reaction to drugs	______
___ Infections	______	___ Allergies	______ List: ______________________________
___ Seizures (Epilepsy)	______	___ Loss of consciousness	______
___ Growth problems	______	___ Concussion(s)	______
___ Tires too easily	______	___ Type 1 Diabetes	______
___ Type 2 Diabetes	______	___ A.D.H.D./A.D.D.	______

Has your child been treated for psychological problems? ___ Yes ___ No If so, when? ______ For what?________________________

___ Outpatient ___ Inpatient **Treatment Type:** ___ Individual ___ Family ___ Medications ____ CBT ____ Behavior Therapy

Treatment Providers: ____

Current & Past Behavioral Concerns

Please indicate concerns you have/had about your child NOW (N) in the PAST (P), or for BOTH (B).

___ Not minding	___ Lack of friends	___ Stealing	___ Excessive video game time
___ Temper tantrums	___ Unacceptable friends	___ Moodiness	___ Excessive screen time
___ Clumsiness	___ Arguing	___ Disorganization	___ Excess social media time
___ Nightmares	___ Memory problems	___ Difficulty sleeping	___ Lying about video, screen, or social media
___ Low self-esteem	___ Lying	___ Frequent crying	___ Other Behaviors ____________________
___ Giving up easily	___ Drug use	___ Verbal fighting	
___ Alcohol use	___ Hitting	___ Tobacco use	
___ Whining	___ Sexual behavior	___ Headaches	
___ Compulsive behaviors	___ Rituals	___ Stomachaches	

Does your child/teen lose items (hats, coats, gloves, book bags, glasses) often? ___ Yes ___ No List: ___________________________

Further History

Has your child or teen ever had problems with the following?

Item	**Check Yes/No**	**Details**	**How Long?**	**Treated?**
Physical abuse?	___Yes ___ No	By whom? ____________________	______________________	___Yes ___ No
Sexual abuse?	___Yes ___ No	By whom? ____________________	______________________	___Yes ___ No
Run away from home?	___Yes ___ No	When? _______________________	______________________	___Yes ___ No
Arrested or adjudicated?	___Yes ___ No	For what? ____________________	______________________	___Yes ___ No
Set a fire?	___Yes ___ No	When/how? ___________________	______________________	___Yes ___ No
Assaulted someone?	___Yes ___ No	Who? ________________________	______________________	___Yes ___ No
Destroyed property?	___Yes ___ No	When? _______________________	______________________	___Yes ___ No

Hurt self?	___Yes ___ No	When? ______________________	Severity: ______________	___Yes ___ No
Threatened to hurt self?	___Yes ___ No	When? ______________________	How? ________________ ______________________	___Yes ___ No
Threatened to hurt someone?	___Yes ___ No	When? ______________________	How? ________________ ______________________	___Yes ___ No
Used a weapon?	___Yes ___ No	When? ______________________	What?________________	___Yes ___ No
Used alcohol or drugs? List: __________________	___Yes ___ No	When? ______________________	How often? ______________________	___Yes ___ No
Used tobacco?	___Yes ___ No	When? ______________________	How often? ___________	___Yes ___ No
Grades drop in school a lot?	___Yes ___ No	When? ______________________	How? ________________	___Yes ___ No
Used tutors/Ed Specialists	___Yes ___ No	When? ______________________	Subjects: ______________ ______________________	___Yes ___ No
Sexually active?	___Yes ___ No	When? ______________________	Partner age? __________	___Yes ___ No
Cruelty to animals?	___Yes ___ No	When? ______________________	How often? ______________________	___Yes ___ No
Rituals, compulsive behaviors?	___Yes ___ No	When? ______________________	How often? ______________________	___Yes ___ No
Shyness or social problems?	___Yes ___ No	What? ______________________	How often? ______________________	___Yes ___ No

Mother: When you ask child/teen to do something what percent of time do they comply? _____ %

Father: When you ask child/teen to do something what percent of time do they comply? _____ %

Does your child teen ever warrant discipline? ___Yes ___ No Situations: ____

Types of Discipline You Employ	Avg. Times/Day	Avg. Length of Time	Child Response
___ Ignoring	______________	________________	______________________________________
___ Spanking	______________	________________	______________________________________
___ Yelling	______________	________________	______________________________________
___ Reward System	______________	________________	______________________________________
___ Lecturing	______________	________________	______________________________________
___ Time Outs	______________	________________	______________________________________
___ Natural Consequences	______________	________________	______________________________________
___ Nothing seems to work well	______________	________________	______________________________________
___ Other	______________	________________	______________________________________

Any other comments about behavioral or emotional regulation issues?

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School History (Schools Attended - Please Include Pre-School and Grades Attended)

School Name	Years Attended	Grades	Comments
1. ____________________________	_______to_______	_____to_____	____
2. ____________________________	_______to_______	_____to_____	____
3. ____________________________	_______to_______	_____to_____	____
4. ____________________________	_______to_______	_____to_____	____
5. ____________________________	_______to_______	_____to_____	____
6. ____________________________	_______to_______	_____to_____	____

Has Your Child Been Classified With/As:

Reading Disability? ___ Yes ___ No If so, first month/year classified: ____/____

Speech Disability? ___ Yes ___ No If so, first month/year classified: ____/____

Language Disability? ___ Yes ___ No If so, first month/year classified: ____/____

Severe emotional disturbed? ___ Yes ___ No If so, first month/year classified: ____/____

Other health impaired? ___ Yes ___ No If so, first month/year classified: ____/____

Specific Health Problems: **A.D.H.D.** ___ Yes ___ No **Type 1 Diabetes** ___ Yes ___ No **Other**: ___ Yes ___ No List: ________________

Is your child currently in special classes or resource room? ___ Yes ___ No

Is your child currently on an **Individualized Educational Plan (IEP)?** ___ Yes ___ No

Is your child currently on a **Section 504 Plan?** ___ Yes ___ No

If yes, which grades has your child been involved in special education services?

___ Pre-K ___ K ___ 1st ___ 2nd ___ 3rd ___ 4th ___ 5th ___ 6th ___ 7th ___ 8th ___ 9th ___ 10th ___ 11th ___ 12th

Does your child receive any accommodations at school? ___ Yes ___ No

If so, what are they? ______________ ______________ ______________ ______________ ______________ __________________

Has your child had individual psychological testing in school? ___ Yes ___ No If so, when? ____________________________________

Referred for: ___________________________________

Has your child been seen by a school counselor? ___ Yes ___ No If so, for: _______________________

Has your child repeated a grade? ___ Yes ___ No If so, which? ____________________

Has your child skipped a grade? ___ Yes ___ No If so, which? ____________________

Have your child's grades changed recently? ___ Yes ___ No If so, how? ____

What were your child's grades last term? ____

Does your child have any behavior problems at school? ___ Yes ___ No If so, list: ____

Does your child have problems getting along with other children? ___ Yes ___ No ____

How many minutes or hours does your child spend on daily homework? _____ Hours _____ Minutes

How long do you or another parent you spend with your child on daily homework? _____ Hours _____ Minutes

As a rule, does your child complete and hand in homework? ___ Yes ___ No

Often completes and hands in homework? ___ Yes ___ No

Often completes, but does not hand in? ___ Yes ___ No

Often neither completes nor hands in? ___ Yes ___ No

How difficult is it for your child/teen to start homework? ___ Very Easy ___ Easy ___ Somewhat Hard ___ Very Hard

How difficult is it for your child to complete homework? ___ Very Easy ___ Easy ___ Somewhat Hard ___ Very Hard

Any further comments or notes about homework, schoolwork, studying, or academic performance?

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Family History

Do any of your FAMILY MEMBERS suffer from these problems? *(Consider family as brothers, sisters, parents, grandparents, aunts, uncles, cousins)*

Condition	**Mother's Family** (List relation)	**Father's Family** (List relation)
Learning Issues	Relation: ______________________ Relation: ______________________	Relation: ______________________ Relation: ______________________
Depression	Relation: ______________________ Relation: ______________________	Relation: ______________________ Relation: ______________________
Alcohol or Drug Problems (Specify):______________________	Relation: ______________________ Relation: ______________________	Relation: ______________________ Relation: ______________________
Mental Retardation	Relation: ______________________ Relation: ______________________	Relation: ______________________ Relation: ______________________
Legal Problems	Relation: ______________________ Relation: ______________________	Relation: ______________________ Relation: ______________________
Hyperactivity	Relation: ______________________ Relation: ______________________	Relation: ______________________ Relation: ______________________
Anxiety Problems	Relation: ______________________ Relation: ______________________	Relation: ______________________ Relation: ______________________
Perfectionism/OCD	Relation: ______________________ Relation: ______________________	Relation: ______________________ Relation: ______________________
Perfectionism	Relation: ______________________ Relation: ______________________	Relation: ______________________ Relation: ______________________
Language, Speech, or Hearing Problems	Relation: ______________________ Relation: ______________________	Relation: ______________________ Relation: ______________________

Tics or Nervous Habits	Relation: ___ Relation: ___	Relation: ___ Relation: ___
Mood Problems	Relation: ___ Relation: ___	Relation: ___ Relation: ___
Behavior Problems	Relation: ___ Relation: ___	Relation: ___ Relation: ___
Anger Problems	Relation: ___ Relation: ___	Relation: ___ Relation: ___
Psychiatric Hospitalization	Relation: ___ Relation: ___	Relation: ___ Relation: ___
Other (List): ___	Relation: ___ Relation: ___	Relation: ___ Relation: ___

Favored Activities or Entertainment

What are your child's favorite activities? ___

What do you like to do with your child? ___

What are your child's strong points? ___

What does your family do together? ___

How often do you read to your child? ___

How often does your child read alone? ___

What are your child's favorite books? ___

Hours your child watches TV on a typical weekday: ____ hours

Hours your child watches TV on a weekend day: ____ hours

Hours your child uses computers per day: ____ hours

Hours your child uses video games per day: ____ hours

Hours your child uses the Internet per day: ____ hours

Does your child have computer use problems? ____ Yes ____ No How often? ___

Does your child **like** to practice anything? ____ Yes ____ No Please list: ___

Does your child play a musical instrument? ____ Yes ____ No What instrument? ___

Exercise

Does your child get regular aerobic exercise? ____ Yes ____ No Hours per week: ______

Does your child play a sport regularly? ____ Yes ____ No Sports: ___

Does your child enjoy sports? ____ Yes ____ No

Friendship History

Does your child have a best friend? ____ Yes ____ No Friend's name: ___

Does your child play with a regular group of children at school? ____ Yes ____ No

Does your child play regularly with a group of children in your neighborhood? ____ Yes ____ No

Does your child show problems getting along with friends? ____ Yes ____ No

Does your child have trouble getting along with siblings? ____ Yes ____ No

Other friend, peers, or sibling issues? ____ Yes ____ No List: ___

Diabetes: Only complete this section if your child has T1 or Insulin Dependent Diabetes Mellitus

Date your child was diagnosed with Type 1 Diabetes: ____/____/____ Age: _______

Endocrinologist: ______________________ What is your child's current insulin regimen? ___ AM ___ Noon ___ PM ___ Night

Does your Child use a CGM? ____ Yes ____ No

Please answer the following about you and your child's reactions to Type 1 Diabetes

QUESTION	MOTHER	FATHER	CHILD/TEEN WITH T1
Feelings when child diagnosed with Type 1:			
Thoughts when your child was diagnosed with Type 1:			
What did you find most difficult about Type 1 In the first year?			
What did you find easiest about Type 1 In the first year?			
What's the hardest thing to cope with in T1?			
What's the easiest thing to cope with in T1?			
What do you do best with diabetes? Strength:			
What about T1 strains your family?			
Are there ways T1 has positively changed your family?			
Who is most supportive for you with T1?			
Is there anyone in the family that is not supportive of well-controlled T1?			

Are you involved in support/research activities or groups related to T1, such as JDRF, ADA, or others?	____________________ ____________________	____________________ ____________________	____________________ ____________________

What causes the most conflict about T1 diabetes in your home?

____

____

____

What would you like to see changed about how T1 is managed in your home?

____

____

____

Are there other specific issues about T1 that concern you?

____

____

____

Any other comments about T1 diabetes in your family?

____

____

____