

Behavioral Diagnostics & Treatment

Antonia Forster, Ph.D., ABPP Michael J Fulop, Psy.D. Ana Cragnolino, Ph.D.
2130 SW Jefferson St., Suite 300, Portland, Oregon 97201-7711

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. _____ |

<u>Parent</u>	<u>Name</u>	<u>Age</u>	<u>Occupation</u>	<u>Race</u>	<u>Education</u>	<u>Contact with Child</u>
Mother:	_____	___	_____	_____	_____	_____
Father:	_____	___	_____	_____	_____	_____
Stepmother:	_____	___	_____	_____	_____	_____
Stepfather:	_____	___	_____	_____	_____	_____

<u>Other Children in Family:</u>	<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Grade</u>	<u>How is School Going?</u>
_____	_____	___	___	___	_____
_____	_____	___	___	___	_____
_____	_____	___	___	___	_____
_____	_____	___	___	___	_____

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

___ Meningitis _____

___ Encephalitis _____

___ Recurrent earaches _____

___ Recurrent respiratory _____

___ Infections _____

___ Seizures (Epilepsy) _____

___ Growth problems _____

___ Tires too easily _____

___ Type 2 Diabetes _____

Previous Illnesses Year

___ Hearing/vision problems _____

___ Concussion/skull fracture _____

___ Ingestion of poison _____

___ Reaction to drugs _____

___ Allergies _____ List: _____

___ Loss of consciousness _____

___ Concussion(s) _____

___ Type 1 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?

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?

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?	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>
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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?
