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On the next several pages you will find a very comprehensive questionnaire. It's completion is required as part of your child's evaluation. Being able to utilize the information you provide, before I see your child, will maximize our time together.

It is lengthy and provides necessary information so that I can best serve you and your child. Also, I realize that some of the information is very private. I will be the only person reviewing your responses. Your child's medical record is located in an electronic medical record; all papers are ONLY shredded personally by my office staff here at the office. A few of the questions will not apply to you or your child. If you have questions about any item, feel free to seek clarification.

I realize your time is valuable and appreciate your collaboration with the therapeutic process. I look forward to meeting with you and your child.

Respectfully,
Sherri Broadwater M.D.

Comprehensive Child and Adolescent History Form

Please fill out the form to the best of your knowledge. If some questions are not applicable to your child, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.

General Information

Date: _____Child's Name_____
First Middle Last

Nickname: _____ Sex: Female Male How does your child self identify? _____

Date of Birth: _____ Age: _____

Child lives at: _____
Address City State Zip Code

Caretakers that the child currently lives with: _____

Does the child live elsewhere during the week or year? Yes No If "Yes", please explain:

_____

Does the child have any siblings? Yes No

If "Yes", please list their names and ages: _____

_____

Does the child live with any of the siblings? Yes No

Please describe living arrangements: _____

_____

Name of person completing form: _____

Relationship to child: _____

Child's Mother's Name: _____
First Middle Last

Mother's Address (only if different from child's address)

_____

Telephone (Day) _____ (Evening) _____

Child's Father's Name: _____
First Middle Last

Father's Address (only if different from child's)

_____

Telephone (Day) _____(Evening) _____

Referral Information

Child's Pediatrician or Family Doctor and Practice Name

Name: _____

Address: _____

Contact Information: Phone Number_____

Fax Number _____ Email Address _____

CURRENT CONCERNS

Why are you bringing your child in for psychiatric care?

_____

_____

What about your child concerns you?

_____

_____

How long has this been a problem / concern?

_____

_____

What have you tried to do to help your child with these concerns? What services have your received?

_____

_____

How do you hope we can help you? What are your goals?

_____

_____

Past Problems

Has your child ever seen a psychiatrist, psychologist or counselor before? No Yes

(Please tell us who and when):

_____

_____

Has your child ever had a psychological evaluation or testing for learning disabilities? No

Yes (Please explain):

_____

Has your child ever taken medication to manage behavioral or emotional problems?

No Yes (Please list the medication and the age when your child took it):

_____

_____

_____

Has your child ever been in the hospital for behavioral or emotional problems? No Yes (Please explain):

_____

_____

_____

Is your child currently under the care of mental health provider? No Yes

Child's Current Mental Health Professional (if applicable):

Name: _____

Address: _____

Telephone: _____ Fax: _____

(Please list medication, dose, and frequency): _____

_____

_____

Has your child ever had any bad reactions to medications for behavioral or emotional problems? No

Yes (please explain): _____

_____

_____

Pregnancy (Mother)
(If child was adopted, parent/guardian can skip questions pertaining to pregnancy and delivery)Please list all of the Mother's pregnancies in order, including the patient.
If a pregnancy ended in miscarriage, state which month.

Year	Mother's Age	Length of Pregnancy	Birth Weight	Complications Yes/No

Please answer which of the following conditions may have occurred during this pregnancy and explain (month, amount, and treatment) in the space below.

Yes	No		Yes	No	
		Edema (swelling of the hands & feet)			Epilepsy
		Vaginal Bleeding			Infections (colds, flu, urinary tract, rubella, vaginal)
		Toxemia			Other illnesses
		Emotional Stress			Cigarettes Used (Avg. # per Day)
		High Blood Pressure			Alcohol Used
		X-ray Studies			Marijuana Used
		Hospitalization			Cocaine Used
		Fever			Heroin Used
		Operations (specify below)			Other Drugs Used
		Medications Used			

Please explain all "Yes"
answers:_____
_____
Was the pregnancy of the child who is coming to the clinic planned? Yes No
How did the parents feel about this pregnancy? _____

How active was this baby during pregnancy? Very Active Active Not Active

Birth History (Child's)
Place (City, State, Country): _____
Hours of Labor: _____
Was the baby delivered on time? Yes No Early, by how much time? _____
Late, by how much time? _____
Type of Labor Onset: Induced Spontaneous Type of Anesthesia: Gas Spinal Local None
Type of Birth: _____ Baby's Presentation: Breech Head Vaginal or C-section

PREGNANCY HISTORY
Was the pregnancy with your child planned? _____
Were you and your significant other
happy?_____
Were there any medical, emotional, or financial problems during the pregnancy period?
_____
Labor or Delivery Difficulties? (Please Explain):
_____
Vaginal or C-section? _____Preterm or Full term? _____ Weeks?
Did you take any medications during the pregnancy? Please explain)
_____
Did you take any substances during the pregnancy? (Please list)
_____
How was your mood during the pregnancy? _____

POST- PARTUM PERIOD
Check which of the following problems may have occurred after the child's birth and explain the amount and treatment in the space below. (PLEASE CIRCLE ALL THAT APPLY).
Trouble breathing Cord around the neck Required a blood transfusion Vomiting
Low Tone Cyanosis (turned blue) Need for ventilation Jaundice Poor Feeding
Hemorrhage (bleeding) in brain Large ventricles (fluid) in brain
Incubator care / premature birth Infection Please explain all "Yes" answers:
_____
How many days was the infant hospitalized after delivery? _____
Did you suffer from the baby blues? Post partum depression, anxiety, mania or psychosis? _____

INFANCY
Was any of the following present in your baby to a significant degree during the first few years of life? (PLEASE CIRCLE ALL THAT APPLY)
Did not enjoy cuddling Difficult to comfort Excessive irritability Difficult feeding Was not calmed by being held or stroked Excessive restlessness Frequent head banging
Please explain all "Yes" answers above:
_____
_____

TEMPERAMENT

Please evaluate the following behaviors your child exhibited during infancy and early childhood.

How active has your child been from an early age? Extremely active Active Not Very Well

How well did your child pay attention? Very Well Average Not Very Well

How well did your child deal with changes? Very Well Average Not Very Well

How well did your child respond to new things (places, people, food, etc.)?

Very Well Average Not Very Well

Very well Average How strong are your child's feelings when happy or unhappy?

Very Well Average Not Very

What was your child's basic overall mood? Happy Irritable Angry

Happy Average How predictable was your child in patterns of sleep, appetite, etc.?

Very regular Average Not very regular

DEVELOPMENTAL MILESTONES

How old was your child when he/she did the following?

(If your child has not yet done the listed activity, please write N/A).

Sit: _____ Crawl: _____ Pedal a 3-wheeler: _____Smile in response: _____

Know primary colors: _____ Walk: _____ Pedal a 2-wheeler: _____Say 1st word other than Mama or Dada: _____ Sound out letters of the alphabet: _____Tie shoes: _____ Cut food with knife: _____

Began to read: _____

Print first & last name: _____Use knife to spread food: _____Buttoned clothing: _____

Toilet trained to urinate: _____ Bowel movement trained: _____

Briefly describe toilet training methods: _____

COORDINATION

How would you rate your child's coordination? When answering this question, think about how your child walks, runs, throws, catches, plays sports in comparison to other children his/her age.

Very well Average With Difficulty

Does your child seem to have an excessive number of accidents compared to other children?

No Yes If"Yes", please explain:

_____

_____

HEALTH HISTORY

Allergies to medications? Allergies to environmental triggers? Exposure to toxins?

_____

When was your child's last physical exam? _____

Medical problems or surgeries- prior and current? (Loss of consciousness, seizures, falls/accidents/head injury? Dates? Hospitalizations? _____

_____

FAMILY MEDICAL HISTORY

Please check Yes or N for each of the conditions below if family members have them. In the space provided below, please indicate who has the illness (mom, dad, grandparents, sisters, brothers, aunts or uncles).

Y N Thyroid Y N Kidney Disease Y N Heart Disease Y N Cancer

Y N High Blood Pressure Y N Sudden Death Y N Vision Problems

Y N Hearing Problems Y N Seizures Y N Cerebral Palsy
Y N Birth Defects Y N Arthritis Y N Lupus
If Yes, please explain who as the illness and its' effect on your child and the family (if any):

_____

_____

Are there any other diseases that run in your family?

_____

FAMILY PSYCHIATRIC HISTORY:
Please check Yes or N for each of the conditions below if family members have them. In the space provided below, please indicate who has the illness (mom, dad, grandparents, sisters, brothers, aunts or uncles).

Y N Schizophrenia Y N Emotional Problems Y N Obsessive- Compulsive DO
Y N Drug Abuse Y N Panic Disorder Y N Alcoholism
Y N Manic Depressive or Bipolar Dx Y N Hyperactivity
Y N Depression Y N Slowness in Talking Y N Nervous Breakdown
Y N Slowness in Walking Y N Tics/Tourette's Disorder Y N Mental Retardation
Y N Bed Wetting After 5 yrs. Y N Learning Problems Y N Delinquency Problem
Y N Trouble with Math Y N Repeated a Grade Y N Trouble with Speech

If Yes, please explain who as the illness and its' effect on your child and the family (if any):

_____

_____

Are there any other diseases that run in your family?

_____

SCHOOL INFORMATION
Name of school _____
Address of school _____
Current Grade _____ Teacher's Name _____
When did your child begin preschool/school? How did it go?

_____

_____

Favorite Subject(s): _____ Typical Grades? _____
Has this changed? Y or N (Please explain)

_____

Special Education Classes? (Please explain - dates, diagnosis, in-class support)

_____

Expelled, suspended, or asked to leave?

_____

_____

Do you interact with other parents? Y or N Do you interact with your child's teachers? Y or N
History of home-schooling? _____
Do you consistently help your child with schoolwork at home? Y or N
Is your child expected to succeed? _____
Is your child expected to study? _____
Does your child like school? If no, why not?_____

_____

HOUSEHOLD INFORMATION
Who does your child live with?

_____

How many siblings does your child have ? (Include step, half, live-in, foster)

_____

Does he/she get along with them all or one/two in particular? Why?

_____

How does your child get along with you? _____ Other parent(s)

_____

_____

Does your child spend time with uncles/aunts/grandparents?

_____

_____

Does your family have a history of frequent moving?

_____

Do you and or your child spend lots of time away from home?

_____

How many rooms are in your home?_____
Is there enough space for your child to play, sleep, and store his/her belongings?_____
Who does or helps your child with school preparation, eating, homework, and bedtime preparation?

_____

_____

Have any household changes contributed to your child's symptoms?

_____

_____

SLEEPING HISTORY
Where does your child sleep?
_____Bedroom other than parent (s) bedroom and not with anyone else.
_____Bedroom parent(s) sleep in
_____Bedroom shared with 1 2 3 4 5 others (not parents)
_____Room other than a bedroom. Where? _____
Does your child have problems falling asleep? Y or N
If yes, how long does it take for her/him to fall asleep? _____ hours.
Does your child wake up in the middle of the night? Y or N
If yes, how many times typically?

How long does it take normally for her/him to go back to asleep after waking during the night?
_____hours.
Does your child snore? Y or N
Is your child restless during sleep? Y or N
Is your child irritable when awakened in the morning? Y or N
How long does this last? _____
Does your child experience: (Please circle) Nightmares, Night terrors, and Sleep Walking/Talking? Please Explain:_____
How many hours does your child currently sleep at night? _____
Does your child nap? _____ If yes, when?_____ How long?

_____

Does your child wet the bed? Y or N How often? _____
Does your child ever have a bowel movement in the bed or place other than the toilet?
_____
_____
Has your child ever been dry after age 5 for more than 6
months?_____
In the past? Y or N How often? _____
Has any treatment been needed? Y or N
Did it work?_____

EATING HISTORY
How would your rate your child's appetite? Poor Fair Good Excellent
Do you believe any particular foods affect your child's behaviors? Y or N

Please state the foods/drink your child intakes and how do they affect her/him?

_____
Are family members who are overweight or underweight? Y or N
Please list them and their relationship to your child? _____
How is your child impacted by the family's member eating habits mentioned above? _____
Do you all eat meals together? Y or N
Does your child eat a lot of junk food? Does your family eat a lot of junk food? Y or N
_____

FRIENDS AND SOCIAL ACTIVITIES
How many close friends does your child have? _____
Has this number changed? Y or N IF yes,
Why?_____
Does your child have a best friend? Y or N IF yes, how old is she or he?
_____
How does your child get along with people Poorly Average Well
If poorly, please explain. _____
_____
Does your child get invited to birthday parties, sleepovers, and or play dates? How does he/she act or behave while there?
_____
_____
What does your child do for fun? How? _____
Can your child entertain himself/herself well? _____
Is there a bullying history? In-home? In-school? Neighborhood? Cyber? Is your child involved in any organized activities in school, after school, or on weekends?
_____
_____ _____
Is your neighborhood safe for her/him to play
outside?_____
How often does your child go outside and play?
_____

MORALS AND DISCIPLINE

Does your child know right from wrong?

_____

Does your child think of others' feelings/actions before acting?

_____

In comparison to other children, how well does your child behave at home or in public?_____

_____

What kind of discipline do you use with your child?

_____

_____

Is there a particular form of discipline that you have found effective?

_____

Have you participated in a parenting class or obtained other forms of information concerning discipline and behavior management? _____

What did you learn and are you able to apply this information?

_____

Who is the primary disciplinarian in the home?

_____

Do you and your significant other agree on the discipline strategies used in your home?

How do your build character and virtues in your child? In your family? _____

Travel and Immigration History

What is your child's immigration status?

_____

Do you and your child spend time out of the US? If so, for what reason(s)?

_____

_____

Has travel for you and or your child been overly long, problematic or upsetting to your child? Please explain:

_____

_____

Are there current concerns regarding the family's immigration status?

_____

Media

1. How much time does your child spend on the telephone, IG, Facebook,playing video games, watching TV, playing video games, watching You-Tube or Netflix or other? During the week on average? On Weekends?

_____

2. How much time does the family spend on the telephone, social media, playing video games, watching TV, playing video games, watching You-Tube or Netflix or other? During the week on average? On Weekends?

_____

3. Does your child have to earn technology time? Yes or No

4. Does your child easily part with technology? Yes or No

5. What is the most prominent impact of your child's use of technology on him or her? _____

HAS YOUR CHILD EVER EXPERIENCED??
Accident? Y N Motor Vehicle? Y N Natural Disaster? Y N
If yes, please give the child's age at which this occurred and a brief explanation:
_____
_____

Major Life Experiences:
Death of a family member? Y N Seen a dead body? Y N Death of a friend? Y N
If yes, please give the child's age at which this occurred and a brief explanation:
_____
_____

Major Illness:
Ever hospitalized? Y N Family member been hospitalized? Y N
Required a medical procedure? Y N Family member requiring a Medical procedure? Y N
If yes, please give the child's age at which this occurred and a brief explanation:
_____
_____

Violence:
Witnessed family violence? Y N Victim of family violence? Y N
Witnessed community Violence? Y N Victim of community violence? Y N
Witnessed school violence? Y N Victim of school violence? Y N
Is your child a perpetrator of violence? Please explain if yes:
_____
_____
If yes, please give the child's age at which this occurred and a brief explanation:_____
_____
Physical Abuse or Emotional Abuse?
Has he/she ever been hit? Y N Visited the Emergency Room? Y N
Referred to Child Protective Service? Y N Belittled? Demeaned? Cursed by an adult?
If yes, please give the child's age at which this occurred and a brief explanation:_____
_____
Sexual Abuse:
Witnessed sexual behavior? Y N Participated in intercourse? Y N
Been touched? Y N Referred to CPS for sexual abuse? Y N
If yes, please give the child's age at which this occurred and a brief explanation:
_____
_____
Neglect:
Failure to Thrive? Y N Is small in size? Y N
Re-eats food that has been chewed? Y N Is never full or steals food? Y N
Referred to CPS for neglect? Y N
If yes, please give the child's age at which this occurred and a brief explanation:
_____
_____

HISTORY

Mother's Information
Marital Status _____ Date of Birth _____
Occupation _____
School History: Highest Grade Completed_____ Learning Problems: Y N _____
Attention Problems Y N _____ Behavioral Problems? Y N _____
Was mother adopted? Y N Was placed out of her home? Y N At what age?_____

Regarding the family in which mother was raised:
Family use of alcohol or drugs? Y N Family Arguments? Y N Domestic Violence? Y N Neglected? Y N Excessive Physical Discipline? Y N
If yes to any response, please explain: _____

Did Mother ever experience:
Physical Abuse? Y N Age?_____ # of times_____ By whom? _____
Sexual Abuse? Y N Age?_____ # of times _____ By whom? _____
Rape? Y N Age?_____ # of times _____ By whom? _____

HISTORY

Father's Information
Marital Status _____ Date of Birth _____
Occupation _____
School History: Highest Grade Completed_____ Learning Problems: Y N _____
Attention Problems _____ Behavioral Problems? Y N _____
Was father adopted? Y N Was placed out of his home? Y N At what age? _____

Regarding the family in which father was raised:
Family use of alcohol or drugs? Y N Family Arguments? Y N Domestic Violence? Y N Neglected? Y N
Excessive Physical Discipline? Y N
If yest to any response, please explain: _____

Did father ever experience:
Physical Abuse? Y N Age?_____ # of times_____ By whom? _____
Sexual Abuse? Y N Age?_____ # of times _____ By whom? _____
Rape? Y N Age?_____ # of times _____ By whom? _____
Additional Comments: