

Velissarios Karacostas, M.D., Ph.D:

Phone # (513) 961-8484

Fax # (513) 487-3760

**CHILD AND ADOLESCENT PATIENT QUESTIONNAIRE**

Who referred your child? \_\_\_\_\_

What was their concern? \_\_\_\_\_

What is your primary concern? \_\_\_\_\_

What is the school's primary concern? \_\_\_\_\_

When did you first become aware of concerns? \_\_\_\_\_

Name of Child: \_\_\_\_\_  
First Middle Last

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State/Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

Religion \_\_\_\_\_ National Heritage \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Eye Color \_\_\_\_\_ Hair Color \_\_\_\_\_

Who has legal custody or guardianship of child? \_\_\_\_\_

**FAMILY DATA**

**FATHER:**

Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Place of Employment \_\_\_\_\_ Title \_\_\_\_\_

Highest Level of Education \_\_\_\_\_ Religious Affiliation \_\_\_\_\_

**MOTHER:**

Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Place of Employment \_\_\_\_\_ Title \_\_\_\_\_

Highest Level of Education \_\_\_\_\_ Religious Affiliation \_\_\_\_\_

**STEPMOTHER:**

Name \_\_\_\_\_ DOB \_\_\_\_\_

Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_  
Fax # ( ) \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Place of Employment \_\_\_\_\_ Title \_\_\_\_\_

Highest Level of Education \_\_\_\_\_ Religious Affiliation \_\_\_\_\_

**STEPFATHER:**

Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Place of Employment \_\_\_\_\_ Title \_\_\_\_\_

Highest Level of Education \_\_\_\_\_ Religious Affiliation \_\_\_\_\_

Please identify marital status including dates of all marriages, divorces and remarriages, for both natural and stepparents.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List on this page in chronological order the names of all children including the applicant, stepbrothers and sisters, half brothers and sisters, and any miscarriages or stillbirths. Also give a brief description of each child. (Birth date, school status, significant characteristics). Please state their relationship to applicant.

NAME	RELATIONSHIP TO YOUR CHILD	SEX	DOB	EDUCATION AND/OR OCCUPATION
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List other children or adults who have lived or are now living in the home and their relationship to the applicant.

\_\_\_\_\_

Phone # ( ) - -  
Fax # ( ) - -

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List dates of moves and for what reasons.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long at present address? \_\_\_\_\_

**DEVELOPMENTAL INFORMATION**

Length of Pregnancy \_\_\_\_\_ Birth Weight \_\_\_\_\_

Planned or unplanned pregnancy \_\_\_\_\_

Was the pregnancy complicated or involved with drugs or alcohol? \_\_\_\_\_

Nature of delivery: \_\_\_\_\_ Natural \_\_\_\_\_ Caesarian \_\_\_\_\_ Breech

Condition of child at time of birth \_\_\_\_\_

If child was adopted, from where? \_\_\_\_\_

At what age was child adopted? \_\_\_\_\_

Age of parent at time of birth or adoption: Father \_\_\_\_\_ Mother \_\_\_\_\_

Please give age your child: crawled \_\_\_\_\_, walked \_\_\_\_\_, talked \_\_\_\_\_, toilet trained \_\_\_\_\_

What have the significant stressors or traumas been to the family and child?

\_\_\_\_\_  
\_\_\_\_\_

**EDUCATION HISTORY**

Where is child attending school now? \_\_\_\_\_

What grade? \_\_\_\_\_

If it is an ungraded class, state approximate grade achieved \_\_\_\_\_  
If child is not enrolled, name last school attended, grade achieved, date withdrawn.

\_\_\_\_\_  
\_\_\_\_\_

List in order of attendance, all school enrollments child has had; also names of tutors, if any. Give name and address. Indicate if it was a public or private school and the grade attended.

School	Address	Public/Private	Average Grade Made

Have any grades been repeated? \_\_\_\_\_

Has the child been identified for special education, learning support or emotional support? Please state year identification and provisions made.  
 \_\_\_\_\_  
 \_\_\_\_\_

Please check those items that pertain to your child:

- Often fails to finish things he or she starts
- Easily distracted
- Has difficulty concentrating
- Shifts excessively from one activity to another
- Frequently is disruptive in class
- Has difficulty awaiting his/her turn (i.e. games)
- Has difficulty sitting still.
- Impulsive or acts without thinking
  
- Abusive to animals
- Physically violent towards property (i.e. vandalism, destructive)
- Physically abusive to self (scratches self, suicidal attempts)
- Firesetting
- Stealing, Shoplifting, Breaking and Entering
- Runaway
- Lying
- Chronic violation of parental limits
- Drug Abuse (what kind?) \_\_\_\_\_
- Alcohol Abuse (what kind?) \_\_\_\_\_
- Any involvement with juvenile court
- Unrealistic fears (Explain) \_\_\_\_\_
- Acts too young for his/her age
- Clings to adults or too dependent
- Feels no one loves him/her
- Gets teased a lot
- Complains of loneliness
- Demands a lot of attention
- Easily made jealous
- Refusal to attend school
- Avoidance of being left alone
- Excessive need for reassurance
- Very self-conscious or easily embarrasses
- Often appears tense and unable to relax
- Frequent physical complaints (i.e. headaches, stomach aches, nausea)

Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_  
Fax # ( ) \_\_\_\_\_ - \_\_\_\_\_

- \_\_\_\_\_ Overly concerned with future events
- \_\_\_\_\_ Nervous mannerisms (i.e. nail biting, thumb sucking, rocking)
- \_\_\_\_\_ Feelings of inadequacy
- \_\_\_\_\_ Panic – feelings of intense fear/discomfort with palpitations, tremors, shortness of breath, choking feelings, etc.
- \_\_\_\_\_ Obsessions – unwanted ideas, images or impulses that intrude on thinking against your wishes and efforts to resist them. (Fear of contamination, recurring doubts about danger, extreme concern with order, symmetry or exactness).
- \_\_\_\_\_ Can't get his/her mind off certain thoughts
- \_\_\_\_\_ Fears he/she may do something bad
- \_\_\_\_\_ Fears she/he has to be perfect
  
- \_\_\_\_\_ Strange thoughts or ideas (Explain) \_\_\_\_\_
- \_\_\_\_\_ Hallucinations – visual or auditory-Describe \_\_\_\_\_
- \_\_\_\_\_ Inappropriate expression of feelings (i.e. laughing at something sad)
- \_\_\_\_\_ Concern that people are out to get him/her
- \_\_\_\_\_ Severe mood changes (i.e. very sad to very happy)
- \_\_\_\_\_ Often appears sad
- \_\_\_\_\_ Confused or seems to be in a fog
- \_\_\_\_\_ Day dreams or gets lost in his/her thoughts
- \_\_\_\_\_ Doesn't seem to have much energy
- \_\_\_\_\_ Social withdrawal
- \_\_\_\_\_ Overtired
- \_\_\_\_\_ Pessimistic outlook toward the future
- \_\_\_\_\_ Excessive tearfulness or crying
- \_\_\_\_\_ Recurrent thoughts about death or preoccupation with death
- \_\_\_\_\_ Suicidal thoughts or verbalized intentions
- \_\_\_\_\_ Concerns about sexual identity
- \_\_\_\_\_ Sexually promiscuous
- \_\_\_\_\_ Inappropriate sexual behavior (Explain) \_\_\_\_\_
  
- \_\_\_\_\_ Poor relationship with parents
- \_\_\_\_\_ Sibling rivalry
- \_\_\_\_\_ Negative peer associates-hangs with others that get in trouble
- \_\_\_\_\_ Argues a lot, bragging, boasting
- \_\_\_\_\_ Mean to others
- \_\_\_\_\_ Has difficulty making or keeping friends
- \_\_\_\_\_ Does not associate with people his or her own age
- \_\_\_\_\_ Avoids unfamiliar social situations
- \_\_\_\_\_ Is easily led by others
- \_\_\_\_\_ Has difficulty participating in organized activities (sports)
- \_\_\_\_\_ Avoids competitive situations.
  
- \_\_\_\_\_ Sleep difficulties (i.e. sleepwalking, restless, inability to fall asleep or sleeps too much)
- \_\_\_\_\_ Eating difficulties (i.e. has difficulty keeping food down, overeats, does not have much of an appetite, fear of trying new foods, tremendous concern about weight).
- \_\_\_\_\_ Poor personal hygiene (does not keep self clean or take an interest in appearance)
- \_\_\_\_\_ Enuretic (urinates during the day or night on self)
- \_\_\_\_\_ Encopretic (soils self)
- \_\_\_\_\_ Deliberately harms self
- \_\_\_\_\_ Tics (sudden rapid, recurrent motor movements or vocalizations)
- \_\_\_\_\_ Behaves like the opposite sex

**PSYCHIATRIC/PSYCHOLOGICAL/MEDICAL**

List all doctors and mental health professionals who have examined and/or treated your child. Please give name, address and phone number for each.

Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_  
Fax # ( ) \_\_\_\_\_ - \_\_\_\_\_

Family Physician \_\_\_\_\_

Dentist \_\_\_\_\_

Orthodontist \_\_\_\_\_

Psychiatrist/Psychologist/or Mental Health Facility \_\_\_\_\_

Medications your child has been on in the past for mood or behavior:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What medication(s) is your child taking now?

\_\_\_\_\_  
\_\_\_\_\_

List any allergic reactions to medications:

\_\_\_\_\_  
\_\_\_\_\_

List any allergies that your child may have and how it is treated.

\_\_\_\_\_  
\_\_\_\_\_

If your child has ever been hospitalized please explain when and for what reason.

Name of Hospital	Date	Diagnosis
_____	_____	_____
_____	_____	_____

Has this child ever been exposed to abuse? Please state whether it is/was physical, emotional or sexual and whether he was the object to the abuse or exposed to it.

\_\_\_\_\_

Please check if any of the following pertain to your child and explain (use back of page if necessary).

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nausea or vomiting    | <input type="checkbox"/> Concussions          |
| <input type="checkbox"/> Lung Disease  | <input type="checkbox"/> Drug or alcohol abuse | <input type="checkbox"/> Nervous disorders    |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Diarrhea (frequently) | <input type="checkbox"/> Neurological testing |

Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_  
 Fax # ( ) \_\_\_\_\_ - \_\_\_\_\_

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Jaundice         | <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> High fevers              |
| <input type="checkbox"/> Seizures         | <input type="checkbox"/> Tonsillectomy                 | <input type="checkbox"/> Injuries or broken bones |
| <input type="checkbox"/> Fainting         | <input type="checkbox"/> Orthodontia                   | <input type="checkbox"/> Accident prone           |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Skin Disease                  | <input type="checkbox"/> Activity limitations     |
| <input type="checkbox"/> Dietary problems | <input type="checkbox"/> Irregular Sleep Patterns      |   |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Visual problems               | <input type="checkbox"/> Speech problems          |
| <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Bowel or elimination problems | <input type="checkbox"/> Other                    |

**GYNECOLOGY**

- Pregnancy  
 Abortion (if so, when) \_\_\_\_\_  
 Miscarriage (if so, when) \_\_\_\_\_  
 Menstrual problems  
 Birth control (if so, what type) \_\_\_\_\_

**FAMILY MEDICAL/PSYCHIATRIC HISTORY**

Please check which, if any, of the following conditions/problems apply to your child's blood relatives. If other significant medical/psychiatric problems are present among blood relatives, please list those in the space provided below.

	Child's Mother	Child's Father	Child's Brother(s)	Child's Sister(s)	Child's Grandp(s)	Other
Childhood oppositional/defiant						
Problems with aggression						
Attentional problem						
Learning disability						
Failed high school						
Mental retardation						
Psychosis/schizophrenia						
Depression (greater than 2 weeks)						
Anxiety or adjustment disorder						
Panic disorder						
Other mental disorder (describe below)						
Tic disorder or Tourette's						
Alcohol Abuse						
Substance Abuse						
Antisocial behavior (assault/thefts)						
Arrests/incarcerations						
Physical abuse (victim)						
Physical abuse (perpetrator)						
Sexual abuse (victim)						
Sexual abuse (perpetrator)						

Name of person completing this form: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_

I do certify that all the foregoing information is true and complete.

NAME \_\_\_\_\_ DATE \_\_\_\_\_