

**Parent Questionnaire
Child Psychiatry**

Patient Information

Patient Name	Gender	Today's date
Parent/Guardian Name	Date of Birth	Age
Address	Home phone	Alternate phone
Completed by	Relationship to child	Recommended by
Services needed (circle): MEDICATION MANAGEMENT THERAPY BOTH		

Instructions: Please circle your answer.

Current Concerns If you answer "YES" to any of the following questions, please explain problem and how long it has existed.

Did a specific event lead to this evaluation? YES or NO

Does the child have problems at home? YES or NO

Does the child have problems at school? YES or NO

Does the child have problems socially? YES or NO

Are there any other events you feel we should know about?

Past Psychiatric History

Has the child been seen by any other psychiatric/psychological providers? YES or NO

If yes, please explain who the child saw and when, the specific reason, and any treatment that was recommended:

Has the child ever been prescribed any psychiatric medications? YES or NO

If yes, please list the medications, when the child was taking them, and if they were helpful if taken as prescribed:

Has the child been hospitalized in a psychiatric unit? YES or NO

If yes, please explain when, where, and why the child was admitted:

Has the child ever attempted suicide? YES or NO

If yes, please explain how many times and what methods were used:

Behaviors

Instructions: Check all of the behaviors that the child exhibits

- | | | |
|--|--|---|
| <input type="checkbox"/> Eye blinking | <input type="checkbox"/> Shoulder shrugging | <input type="checkbox"/> Bending over and twisting around |
| <input type="checkbox"/> Grimacing | <input type="checkbox"/> Slapping hands on thigh | <input type="checkbox"/> Jerking or kicking movements of the leg/foot/toe |
| <input type="checkbox"/> Sticking out tongue | <input type="checkbox"/> Repeating what others say | <input type="checkbox"/> Touching parts of the body |
| <input type="checkbox"/> Facial twitching | <input type="checkbox"/> Throat clearing | <input type="checkbox"/> Grunting |
| <input type="checkbox"/> Eye rolling | <input type="checkbox"/> Eyebrow raising | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Lip licking | <input type="checkbox"/> Nose twitching | <input type="checkbox"/> Whistling |
| <input type="checkbox"/> Clapping hands | <input type="checkbox"/> Head jerking | <input type="checkbox"/> Sniffing |
| <input type="checkbox"/> Touching other people | <input type="checkbox"/> Flapping arms | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Gurgling | <input type="checkbox"/> Hissing | |
| <input type="checkbox"/> Repeating words | <input type="checkbox"/> Uncontrollable cursing | |

If you marked any of the above behaviors, please explain when they started and if they still occur.

Sleeping Behaviors

Instructions: Check all of the symptoms that the child have EVER experienced

- | | | | |
|---|---|---|-------------------------------|
| <input type="checkbox"/> Problems falling asleep (in bed) | <input type="checkbox"/> Problem staying asleep | <input type="checkbox"/> Trouble with awaking early | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Trouble getting child to bed | <input type="checkbox"/> Snoring | <input type="checkbox"/> Sleep apnea | |

What time does the child go to sleep on school days? _____

What time does the child wake up on school days? _____

Instructions: If you answer yes to any of the following questions, please explain.

Does the child share a bed and/or bedroom? With whom? YES or NO

Does the child have nightmares? How often and of what? YES or NO

Does the child wet the bed? How often? YES or NO

Life Events Instructions: Make a check mark where appropriate

Has child experienced any of the following during his/her lifetime?

EVENT	Age/Date	Please explain what happened and when
Starting a new sitter, daycare, or preschool		
Starting a new school		
Birth of a new sibling		
Family move to a new home		
Chronic parental quarreling/arguing		
Known or suspected physical or sexual abuse		
Separation or divorce of parents		
Death in the family		
Major illness of a family member		
Hospitalization of a family member		
Remarriage of a parent		

Developmental History No information available

How many pregnancies did the mother have prior to this child? _____

How many live births did the mother have prior to this child? _____

Instructions: Check all of the events that occurred during the pregnancy or delivery of this child:

- | | | |
|---|---|--|
| <input type="checkbox"/> Severe nausea | <input type="checkbox"/> Cesarean section | <input type="checkbox"/> Infant required blood transfusion |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Incompatible RH factor | <input type="checkbox"/> Infant required oxygen |
| <input type="checkbox"/> 1st trimester bleeding | <input type="checkbox"/> Breech delivery | <input type="checkbox"/> Infant was placed in incubator |
| <input type="checkbox"/> 2nd trimester bleeding | <input type="checkbox"/> Premature delivery (more than 2 weeks) | |
| <input type="checkbox"/> 3rd trimester bleeding | <input type="checkbox"/> Late delivery (more than 2 weeks) | |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Umbilical cord around neck | |

If you checked any of the above, please explain what was done to resolve the issue:

Were there any other problems with the pregnancy or delivery? YES or NO

If yes, please explain what they were and how they were resolved:

Did the mother consume any medications while pregnant with this child? YES or NO

If yes, please explain what and why it was taken:

Developmental History (continued)

Did the mother use alcohol or illegal drugs while pregnant with this child? YES or NO
 If yes, please explain which one(s) and duration of use:

What was the child's weight at birth? _____ pounds _____ ounces

Did the child stay in the hospital after the mother returned home? YES or NO

If yes, please explain why the child stayed and for how long:

What age did the child reach the following milestones?

Walking without assistance: _____

Spoke first word: _____

Used a full sentence: _____

Dressed without supervision: _____

Fully toilet trained: _____

Were there any difficulties with any of the above milestones? YES or NO

If yes, please explain difficulty and how it was resolved:

Instructions: Check all of the difficulties the child had during their speech development

- Delayed speech
- Did not use "I" or "me"
- Stammering
- Talked excessively
- Hard to understand
- NONE

If you checked any of the above, please indicate whether or not it is still an issue:

If it is no longer an issue, please indicate what steps were taken to resolve it:

If it continues to be an issue, please indicate what, if anything, is being done to help it:

Child/Adolescent Lifestyle:

Caffeine use (how much per day):	Exposure to second-hand smoke regularly? Yes or No
Alcohol use (how much per day/week/month)	Vape/Chew/Smoke Nicotine: Yes or No How often?
Nutrition concerns (over/under eating, restrictive, avoidant)	THC Use? Other illicit drug use?
Self-injury? Frequency, type, has medical attention been required?	Electronic use (phone/video games/tv/computer) how many hours per day?
Sports/activities/clubs:	Gender/Sexual Orientation:

Medical History

Primary Care Provider	Location
Case Manager	Location
Individual/Family Therapist	Location

Medical History (continued)

Symptoms

Instructions: Check all that the child experienced in the past few months

- | | | |
|---|--|---|
| <input type="checkbox"/> Fever (last month) | <input type="checkbox"/> Any trouble with vision | <input type="checkbox"/> Nipple discharge |
| <input type="checkbox"/> Doubled/blurred vision | <input type="checkbox"/> Diminished hearing | <input type="checkbox"/> Breast lump |
| <input type="checkbox"/> Change of a mole on skin | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Slurred speech | <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Muscle pain/stiffness |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Joint stiffness/swelling |
| <input type="checkbox"/> Skin sores | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Back pain/stiffness | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Excessive urination | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Chronic PAIN |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Excessive bruising | <input type="checkbox"/> Enlarged lymph nodes | |

If you marked any of the above symptoms, please explain what, if anything, was done to correct it and/or if it is still present:

Health Conditions

Has child experienced any of the following health issues?

Condition	Yes	If you checked the "yes" box, explain condition and describe when it began or diagnosed
Heart Problems		
Asthma		
Seasonal Allergies		
Medication Allergies		
Special Diet/Food Allergies		
Seizures		
Head Injury/Lacerations		
Loss of Consciousness		
CAT Scan or MRI of the head (date)		
Serious accident/ER Visit (date)		
Hospitalization (date)		

Are there any integrative or culturally specific interventions or treatments we should be aware of? _____

Social History

Instructions: Check all of the following that apply to the child

- African American Asian Caucasian Hispanic Other, specify: _____

Did/Does either parent/guardian serve in the US Military? Branch? Type of discharge?

Are the biological parents of the child still together? YES or NO

- Married Separated Living together/not married

Are both biological parents still alive? If not, what happened, when?

Family History:**Is there a known family history of any of the following:**

Disorder	Who?	Explain: indicate when diagnosed or what happened
Depression		
Bipolar/Manic Depression		
Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)		
Post-Traumatic Stress Disorder (PTSD)		
Borderline Personality Disorder		
Learning Disorder		
Tic Disorder		
Schizophrenia		
Obsessive Compulsive Disorder		
Alcohol Abuse/Dependence		
Drug Abuse/Dependence		
Suicide Attempts		
Suicide Completions		
Serious Crimes		

Custody

Who has legal custody of the child?
Who has physical custody of the child?
If there is a parenting time agreement, please describe the schedule: _____ _____ _____

Biological Mother History No information available (skip this section)

Name		Date of Birth	
Telephone Number	Address (if different from child's)		Highest level of Education
Present Occupation	Name of Employer		Work Number
Instructions: If biological parents are no longer together, please complete the following section:			
Is the mother currently in a relationship? YES or NO If yes, with whom? _____			
Check which of the following best describes the relationship. <input type="checkbox"/> Dating <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Separated			
Is the mother living with significant other?			
Significant other's highest level of education?			
Significant other's place of employment?			

Biological Father History No information available (skip this section)

Name		Date of Birth
Telephone Number	Address (if different from child's)	Highest level of Education
Present Occupation	Name of Employer	Work Number
Instructions: If biological parents are no longer together, please complete the following section:		
Is the father currently in a relationship? YES or NO If yes, with whom? _____		
Check which of the following best describes the relationship. <input type="checkbox"/> Dating <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Separated		
Is the father living with significant other?		
Significant other's highest level of education?		
Significant other's place of employment?		

Guardian Information (if different than parent)

Name		Date of Birth	Telephone Number
Telephone Number	Past or current military service		Highest level of Education
Present Occupation	Name of Employer		Work Number
Is the guardian above, currently in a relationship? YES or NO If yes, with whom? _____			
Check which of the following best describes the relationship. <input type="checkbox"/> Dating <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Separated			
Is the guardian living with significant other?			
Guardian significant other's highest level of education?			
Guardian significant other's place of employment?			

Guardian Information (If second guardian is applicable)

Name		Date of Birth	Telephone Number
Telephone Number	Past or current military service		Highest level of Education
Present Occupation	Name of Employer		Work Number
If the two guardians are in a relationship together, please skip the following section.			
Is the guardian above, currently in a relationship? YES or NO If yes, with whom? _____			
Check which of the following best describes the relationship. <input type="checkbox"/> Dating <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Separated			
Is the guardian living with the significant other?			
Guardian significant other's highest level of education?			
Guardian significant other's place of employment?			

Siblings

How many full biological siblings does the child have?				Living with?	
Sibling Name	Age	Grade	Yes	No	
How many half biological siblings does the child have?				Living with?	
Sibling Name	Age	Grade	Yes	No	
How many step siblings does the child have?				Living with?	
Sibling Name	Age	Grade	Yes	No	
How many foster siblings does the child have?				Living with?	
Sibling Name	Age	Grade	Yes	No	
Who lives in each of the child's home's?					

Legal History

Does the child have a probation or truancy officer? YES or NO
 If yes, please state their name and location:

Has the child ever been in court? YES or NO
 If yes, please explain how many times, for which offenses, and what the result was each time:

Academic History

Instructions: If it is summer, list the grade the child will be entering next school year.

Current School:		District Name:	
Current Grade:	Does the child have an IEP?	Does the child have a Health Plan?	Does the child have a 504 plan?
How many days of school did the child miss during this academic year? _____ days in-school suspensions _____ days skipped _____ days out-of-school suspensions _____ days missed because of an illness			
Does the child enjoy school?			

Instructions: Check all of the following that apply to the child

- Skipped grade
- Held back a grade
- Received tutoring
- Received remedial reading
- Attended program for the gifted
- Special pre-school program
- Attended a resource room for part of the day
- Currently participates in targeted services

If you marked any of the above, please explain in more detail:

How well does the child perform in each of the following subjects?

Instructions: Make a check mark where appropriate

Topic	Failing	Below Average	Average	Above Average	NA
English/reading					
Mathematics					
Science					
History/social studies					
Foreign language					
Physical education					

GAD-7

Over the past 2 weeks, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid something awful might happen	0	1	2	3

Total score = _____ = _____ + _____ + _____ + _____

PHQ-A

Date _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
 Yes No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?
 Not difficult at all Somewhat difficult Very difficult Extremely difficult

Total score = _____ = _____ + _____ + _____ + _____

Kiddie-Cage

- Have you used more than one chemical at the same time in order to get high? Yes No
- Do you avoid family activities so you can use? Yes No
- Do you have a group of friends who use? Yes No
- Do you use to improve your emotions such as when you feel sad or depressed? Yes No



Authorization for Disclosure of Personal Health Information

Patient Identification	Name: _____ Date of Birth: _____ Address: _____ Phone Number: _____ City/State/Zip: _____ Maiden/Previous Names/Nickname: _____																		
Provider (Who is releasing Information?)	Provider/Facility Name: _____ Address: _____ City/State/Zip: _____ Phone Number: _____																		
Disclose Information To: (Where is information to be sent?)	Name/Facility: _____ Madelia Health Hospital & Clinic _____ Address: _____ 121 Drew Ave. SE _____ City/State/Zip: _____ Madelia, MN 56062 _____ *PLEASE MAIL IF OVER 50 PAGES, DO NOT FAX * Phone Number: ___(507) 642-3255_____ Fax: ___(507) 642-8010_____																		
Information to be Disclosed	<table border="0"> <tr> <td><input type="checkbox"/> Hospital Progress Notes</td> <td><input type="checkbox"/> History & Physical</td> <td><input type="checkbox"/> Pathology Report</td> </tr> <tr> <td><input type="checkbox"/> EKG/Cardiology Reports</td> <td><input type="checkbox"/> Discharge Summary</td> <td><input type="checkbox"/> Physical Therapy Notes</td> </tr> <tr> <td><input type="checkbox"/> Radiology Reports</td> <td><input type="checkbox"/> Operative Report</td> <td><input type="checkbox"/> Outpatient Information</td> </tr> <tr> <td><input type="checkbox"/> ER Records</td> <td><input type="checkbox"/> Lab Data</td> <td><input type="checkbox"/> Consultation</td> </tr> <tr> <td><input type="checkbox"/> Patient Portal Information</td> <td></td> <td><input type="checkbox"/> All Records</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other (Specify)</td> </tr> </table>	<input type="checkbox"/> Hospital Progress Notes	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Pathology Report	<input type="checkbox"/> EKG/Cardiology Reports	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Physical Therapy Notes	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Outpatient Information	<input type="checkbox"/> ER Records	<input type="checkbox"/> Lab Data	<input type="checkbox"/> Consultation	<input type="checkbox"/> Patient Portal Information		<input type="checkbox"/> All Records	<input type="checkbox"/> Other (Specify)		
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Service Dates	Time period from: _____ to _____ Concerning: _____ (specific diagnosis or treatment, auto accident, etc.)																		
Purpose of Disclosure	<table border="0"> <tr> <td><input type="checkbox"/> Continuing Medical Care</td> <td><input type="checkbox"/> Consult/Second Opinion</td> <td><input type="checkbox"/> Out of town move</td> </tr> <tr> <td><input type="checkbox"/> Insurance Claim</td> <td><input type="checkbox"/> Legal</td> <td><input type="checkbox"/> Personal</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other (Specify)</td> </tr> </table>	<input type="checkbox"/> Continuing Medical Care	<input type="checkbox"/> Consult/Second Opinion	<input type="checkbox"/> Out of town move	<input type="checkbox"/> Insurance Claim	<input type="checkbox"/> Legal	<input type="checkbox"/> Personal	<input type="checkbox"/> Other (Specify)											
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Expiration Date	This authorization will expire one year from the date of signature or on _____																		
Revocation	I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if: (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.																		
Authorization	I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section entitled "Disclose Information To", I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits. _____ Signature of patient/representative _____ Signature Date _____ (Relationship to patient, if signed by representative) (Reason patient unable to sign) (Witness – optional) Please supply proof of authority to act. For minors, proof only required if other than parent.																		
Internal Use Only:	Info needed by: _____ Date sent: _____ Sent by: _____ <input type="checkbox"/> Authority to act attached <input type="checkbox"/> ID Validated Records to be: <input type="checkbox"/> Mailed <input type="checkbox"/> Will pick up Need to call pt when ready? <input type="checkbox"/> Yes <input type="checkbox"/> No Phone #: _____																		