Managed Health Care Administration
Initial Assessment Child/Adolescent Program
Parent Questionnaire

Clinician Notes:

Date: _____

Patient Name: _____ Date of Birth: ____/____/____

Age of Patient: _____ Name of person completing this form_____

Relationship to Patient: _____

Dear Parent: The information that you provide is critical in providing an accurate diagnosis and treatment of the problem. If you require additional space to answer any of these questions, please write on the back of the page and list the number of the question being answered. If you do not know the answer to a question please leave it blank.

I. Please describe, in detail, the present problem (including when the problem started, how often it occurs, what stressors may contribute to the problem, etc.)

Has your child received any previous treatment for the problem? Yes ☐ No If yes, explain:

II. Medical History:

Name of Pediatrician or Family Doctor: _____
Date last seen: _____

Would you like our findings and recommendations sent to your pediatrician? ☐ Yes ☐ No

Please check any of the following medical conditions for which your child was ever evaluated or diagnosed:

☐ Seizures	☐ Heart Problems	☐ Weight Problems	☐ Head Injury
☐ Asthmatic condition	☐ Chronic Fatigue	☐ Chronic Headaches	☐ Depression
☐ Chronic Hearing Loss	☐ Stomach Problems	☐ Suicidal Thoughts	☐ Surgeries

☐ Other _____

Please explain any item that you checked and list any medication(s) that were *previously* prescribed.

Allergies (Please list all of your child's allergies):

Current Medications (Please list all of your child's current medications other than above):

Clinician Signature:

_____

Clinician Notes:

III. Past Psychiatric/Psychological History:

Has your child ever received psychiatric services or counseling? ☐ Yes ☐ No If yes, please explain and include dates of service, location, clinician's name.

List any psychiatric or mood medications that your child has been prescribed in the past (if more than 3 medications, use the back of this page):

Name of medication	Prescribed by	Dose level	Side effects
1.			
2.			
3.			

IV: Developmental History:

A: Relating to your child's birth:

Your child's weight at birth: ____lbs. ____oz. Was this a full term birth? ☐ Yes ☐ No If no, explain:

Did either parent use drugs or alcohol at the time of conception? ☐ Yes ☐ No If yes, explain:

Were there any complications with the labor & delivery such as jaundice, infection etc.? ☐ Yes ☐ No If yes, explain:

Were there any problems after birth? ☐ Yes ☐ No If yes, explain:

B. Pre-school/Toddler Temperament: Please check the following items that apply.

☐ Did not enjoy being held	☐ Excessive restlessness	☐ Colic
☐ Feeding problems	☐ Sleep problems	☐ Head-banging
☐ Sensitive to light / noise / texture	☐ Fussy or unhappy	☐ Difficulty bonding

C. Developmental Milestones: Please indicate the approximate age in months when your child achieved the following tasks:

_____ Sitting alone _____ Walking _____ Put words together _____ Toilet trained

D. Unusual behaviors/Speech patterns:

☐ Spinning	☐ Putting things in the mouth	☐ Repeating words or phrases inappropriately
☐ Hand flapping	☐ Sniffing excessively	☐ Saying "I" for "You"

V. School/daycare History:

Did your child attend daycare? ☐ Yes ☐ No If yes, what was their age? ____ Any problems? _____

What were your child's grades on their last report card? _____

What is the name of your child's primary teacher? _____

Clinician Signature:

_____

Clinician Notes:

Name of **Current School:**	Dates Attended	Present Grade Placement	Behavior Problems	Learning Problems
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

Name of **Past Schools:**	Dates Attended	Present Grade Placement	Behavior Problems	Learning Problems
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

Has your child ever been:
evaluated for a learning disability? ☐ Yes ☐ No If yes, what grade? _____ When? _____

placed in Special Education Classes? ☐ Yes ☐ No If yes, what type of class? _____

_____

tested by the school system? ☐ Yes ☐ No If yes, when? _____

expelled or suspended? ☐ Yes ☐ No If yes, please describe: _____

_____

Does your child have a current IEP (Individual Education Plan)? ☐ Yes ☐ No
Does your child have a current 504 plan? ☐ Yes ☐ No

VI. Legal / Juvenile Court / Alabama State Department of Human Resources (DHR):

Has your child been: arrested? ☐ Yes ☐ No
assigned a probation officer? ☐ Yes ☐ No If yes, their name: _____
jailed? ☐ Yes ☐ No

Has your child: ever appeared in juvenile court? ☐ Yes ☐ No
or other family member ever been reported to DHR? ☐ Yes ☐ No
been assigned a DHR caseworker? ☐ Yes ☐ No
If yes, their name: _____
ever been a victim of child physical or sexual abuse? ☐ Yes ☐ No

If you answered yes to any of these questions, please explain:

VII. Family Medical History:

Clinician Signature: _____

☐ Sudden death ☐ Heart disease (especially dysrhythmias) ☐ Diabetes mellitus
☐ Obesity ☐ Narrow Angle Glaucoma ☐ Seizures

Clinician Notes:

VIII. Family Psychiatric History:

Has any member of your child's family been treated for depression, bipolar disorder, schizophrenia, anxiety, suicidal thoughts, alcohol or other drug problems, learning disabilities or ADD/ADHD, etc.? ☐ Yes ☐ No If yes, please explain:

IX. Social / Family History:

Biological mothers' full name: _____ Biological fathers' full name: _____

Biological parents marital status: ☐ Married to each other ☐ Divorced ☐ Separated

If divorced from one another, has either remarried? Mother ☐ Yes ☐ No
Father ☐ Yes ☐ No

If the biological parents are divorced or separated, who has custody of the patient? _____

Type of custody? _____

Stepmothers' name: _____

Stepfathers' name: _____

List all relatives who presently live in the same household as your child (if more than 5 please list on back of this sheet):

Name	Relationship	Type of Employment / Student Grade Level
1.		
2.		
3.		
4.		
5.		

Please check any of the following stressors that presently affect your child:

☐ Family financial problems
☐ Child rearing problems
☐ Health problems
☐ Peer relationships
☐ "Other" problem _____
☐ Family relationships
☐ Drug or alcohol problems
☐ Employment problems
☐ Frequent change of household
☐ Legal problems
☐ Abuse behavior
☐ School problems
☐ Frequent moves

Please explain how any item you checked affects your child.

Clinician Signature:

_____

Reminder: Please bring a copy of any custody papers to the initial appointment.

Managed Health Care Administration
Child / Adolescent Initial Assessment
Initial Assessment – "Mental Status Examination"

Patient's Name: _____ **Date:** _____

Mental Status examination: symptoms (check all that apply - comment as appropriate)

Category:	**Symptoms:**
Attire/grooming	age appropriate _____ inappropriate _____
Hygiene	good _____ poor _____
Physical appearance	mature _____ average _____ immature _____
Attitude toward interviewer	congenial _____ hostile _____ ambivalent _____ solicitous _____
Relationship to care giver	enmeshed _____ appropriate _____ detached _____
Motoric activity:	appropriate _____ agitated _____ accelerated _____ retarded _____
coordination:	appropriate _____ inappropriate _____
tics, mannerisms et. al.	describe _____
Affect	appropriate _____ inappropriate _____ anxious _____
Mood: anxious _____	fearful _____ angry _____ euthymic _____
sad _____	relaxed _____ depressed _____ suspicious _____
guilty _____	ashamed _____ indifferent _____
Memory	undisturbed _____ impaired _____
Intelligence	above average _____ average _____ below average _____
Thoughts	logical _____ blocking _____ other _____
Hallucinations	visual ____ auditory _____ olfactory _____ none _____
Delusions	grandiose _____ somatic _____ persecutory _____ other _____ none _____
Judgement	poor _____ age appropriate _____
Attention span	satisfactory _____ distracted _____ poor _____
Speech	coherent _____ pressured _____ concrete _____ tangential _____
	age appropriate _____
Suicidal ideation	yes _____ no _____
Homicidal ideation	yes _____ no _____

Clinician Signature: _____

Managed Health Care Administration
Child / Adolescent Initial Assessment
Clinician Summary Sheet

Patient's Name: _____ **Date:** _____

VI. Diagnosis:

Axis 1_____ **Axis 2**_____

Axis 3_____ **Axis 4**_____

Axis 5_____

VII . Clinician Summary:

Clinician Signature: _____ **Date:** _____