CHILD AND ADOLESCENT
FAMILY, HEALTH, AND DEVELOPMENTAL INFORMATION FORM / SDQ

****Completed by Parent/Caregiver****

DATE______________________

GENERAL INFORMATION

Child's Name: ______________________________ Sex____ Age____ Birthdate____________________

Address: _________________________________ Phone: Home____-____-______ Cell ____-____-______

City: __________________________________ County: ____________________________

Referred by: _______________________________ Race/Ethnic Background: ______________

Form Completed By: ___________________________ Relationship to Client: ______________

CURRENT PROBLEMS

1. Describe child's current problem(s) – behavioral, emotional: ______________________________

____

____

2. When did the current problem start? ______________________________________
3. Do you feel that your child is aware of the problem? ______ Yes ______No

   If yes, how is this awareness expressed? ____________________________________
4. What do you think is the cause of the current problem(s)? ___________________________

____

____

5. Do mother and father agree on the existence or extent of the problem? ______Yes ______No

   If no, explain. ____
6. What solutions have you tried so far? How did they work? ___________________________

____

____

STRESSORS/TRAUMA HISTORY

1. Has the child experienced any of the following and what age was the child?

Check if apply	Event	Age	Description
	Move to a new place		
	Change of school		
	Serious illness or injury in family		
	Death of a parent		
	Death of a close friend, relative, or pet		
	Change in family's financial status		
	Parental separation or divorce		
	Prolonged separation from parent		
	New person in household		
	Physical Abuse		
	Sexual Abuse		
	Emotional Abuse		
	Witnessed violence towards family member		
	Accident or serious injury		
	Other stressful or traumatic events:		

CHILD SYMPTOM CHECKLIST

Parents: In an effort to best understand the concerns you have regarding your child, please indicate which of the following behaviors you have observed in your child and are concerned about at this time. The more complete the information you provide us, the better we will be able to work with you and your child. Circle the response that best matches your concern.

1=No Problem 2=Present 3=Concerned 4=Very Concerned 5=Severe Concern

SECTION #1

Date symptoms began ________	1=No Problem				5=Severe
Careless mistakes	1	2	3	4	5
Difficulty paying attention	1	2	3	4	5
Difficulty listening	1	2	3	4	5
Doesn't finish tasks	1	2	3	4	5
Problems organizing self, disorganized	1	2	3	4	5
Avoids tasks that require sustained attention	1	2	3	4	5
Makes careless mistakes	1	2	3	4	5
Loses needed items	1	2	3	4	5
Easily distracted	1	2	3	4	5
Forgetful	1	2	3	4	5
Fidgets, squirms	1	2	3	4	5
Leaves seat when required to sit	1	2	3	4	5
Often on-the-go, restless, seems driven	1	2	3	4	5
Runs, climbs excessively	1	2	3	4	5
Talks excessively when expected to be quiet	1	2	3	4	5
Problems waiting for turn	1	2	3	4	5
Interruptive	1	2	3	4	5

SECTION #2

Date symptoms began: ________	1=No Problem				5=Severe
Touchy, easily annoyed	1	2	3	4	5
Argumentative	1	2	3	4	5
Defiant towards adult requests	1	2	3	4	5
Angry or resentful	1	2	3	4	5
Throws tantrums or loses temper	1	2	3	4	5
Bothers other deliberately	1	2	3	4	5
Blames others for own mistakes	1	2	3	4	5
Uses obscene language with others	1	2	3	4	5

SECTION #3

Date symptoms began: ________	1=No Problem				5=Severe
Bullies/Threatens others	1	2	3	4	5
Starts fights	1	2	3	4	5
Stealing/Shoplifting	1	2	3	4	5
Used a weapon	1	2	3	4	5
Physically cruel to people	1	2	3	4	5
Breaks curfew	1	2	3	4	5
Physically cruel to animals	1	2	3	4	5
Forcibly stolen from a victim	1	2	3	4	5
Stolen without confronting victim	1	2	3	4	5
Deliberately destroys property	1	2	3	4	5
Deliberately starts fires	1	2	3	4	5
Forces someone to engage in sexual behavior	1	2	3	4	5
Dishonest, is manipulative	1	2	3	4	5
Running away, leaving home without permission	1	2	3	4	5
Truancy, unexcused absences from school	1	2	3	4	5
Change in peer group	1	2	3	4	5
Uses alcohol/drugs	1	2	3	4	5
Legal problems	1	2	3	4	5

SECTION #4

Date symptoms began ________	1=No Problem				5=Severe
Energy level changes	1	2	3	4	5
Sleep disturbances	1	2	3	4	5
Appetite or weight change	1	2	3	4	5
Concentration problems	1	2	3	4	5
Depressed or sad mood	1	2	3	4	5
Crying spells	1	2	3	4	5
Loss of interest or pleasure	1	2	3	4	5
Feelings of hopelessness	1	2	3	4	5
Guilty feelings	1	2	3	4	5
Isolates self or withdrawn	1	2	3	4	5
Low self-esteem	1	2	3	4	5
Thoughts of death or suicide	1	2	3	4	5
Self-injurious behaviors	1	2	3	4	5
Sudden unpredictable mood changes	1	2	3	4	5
Bizarre behaviors	1	2	3	4	5
Rage outbursts	1	2	3	4	5
Rapid, hard to follow speech	1	2	3	4	5

SECTION #5

Date symptoms began: ________	1=No Problem				5=Severe
Excessive worries	1	2	3	4	5
Worries about trauma to self/parent	1	2	3	4	5
Experience panic attacks	1	2	3	4	5
Avoids being alone, clingy	1	2	3	4	5
Nightmares or sleep disturbances	1	2	3	4	5
Ruminating thoughts	1	2	3	4	5
Needs adult close by to sleep	1	2	3	4	5
Physical somatic complaints	1	2	3	4	5
Obsessive thoughts	1	2	3	4	5
Compulsive behaviors, rigid rituals	1	2	3	4	5
Extreme fear of new places/situations	1	2	3	4	5
Feelings of tension, inability to relax	1	2	3	4	5
Intense fears or phobias	1	2	3	4	5

SECTION #6

Date symptoms began: ________	1=No Problem				5=Severe
Significant weight loss	1	2	3	4	5
Fear of gaining weight	1	2	3	4	5
Recurrent episodes of binge eating	1	2	3	4	5
Persistent concern with body/weight	1	2	3	4	5
Excessive exercise	1	2	3	4	5

SECTION #7

Date symptoms began: ________	1=No Problem				5=Severe
Repetitive/unusual body movements	1	2	3	4	5
Resists change in environment, routine	1	2	3	4	5
Seems aloof, socially withdrawn	1	2	3	4	5
Sensory sensitive	1	2	3	4	5
Avoids eye contact	1	2	3	4	5
Hears voices/sees images	1	2	3	4	5
Stares off into space, seems blank	1	2	3	4	5
Odd thinking/unusual fixed interests	1	2	3	4	5

MENTAL HEALTH HISTORY

1. Any previous mental health treatment for the child? _____Yes _____No
   If yes, please describe program (therapy, hospitalizations, placements, etc.) and date of attendance:
   ____
   ____
   ____
2. Has your child been on medication for emotional, behavioral, neurological problems? ____Yes ____No
   If yes, indicate medication, dosage: ____
   ____
3. Is there any family history of the following problems?

____ Depression
____ Eating Disorder
____ ADHD
____ Chemical Dependency
____ Suicide thoughts/attempts
____ Anxiety
____ Learning Disabilities
____ Other: ______________________
____ Bipolar Disorder
____ Schizophrenia
____ Seizure Disorder

DEVELOPMENTAL HISTORY

Pregnancy

1. Was this pregnancy:
   Planned? _____Yes _____No
   Desired by mother? _____Yes _____No
   Desired by father? _____Yes _____No
   Of normal duration? _____Yes _____No
2. Was there a gender preference? _____Yes _____No
3. Were there any medical problems or stressors during pregnancy? _____Yes _____No
   If yes, explain____
   ____
4. During the course of pregnancy:
   Did mother take any medications? _____Yes _____No
   If yes, what kind and how long? ______________________________
   Did mother smoke cigarettes? _____Yes _____No
   If yes, how many daily and for how long? ______________________________
   Was mother dependent on or taking drugs/alcohol? _____Yes _____No
   If yes, please give details: ______________________________
   Did mother have any x-rays? _____Yes _____No
   If yes, when during pregnancy and how many? ______________________________
5. What month during the pregnancy did mother start seeing the doctor regularly? ____________

Delivery

1. Did mother experience any complications during or after delivery? _____Yes _____No
   If yes, please explain ____
   ____
2. Did the child experience any problems during or after delivery? _____Yes _____No
   If yes, please explain ____
   ____

Early Development

1. Was the child: _____ breast fed _____ formula fed _____ both
2. Were there any feeding problems, colic, or food allergies? ______________________________

   ____
3. Were there any changes in the child's primary caretakers during the first 3 years of life? _________

   ____
4. Was the child attached to any inanimate objects (e.g. blanket, teddy bear)? If yes, what object and at what age?

   ____

5. Developmental Milestones (check one for each)

	Normal Range	Early	On-Time	Late	Unknown/Unsure
Established eye contact	0-3 months				
Smiling	3-6 months				
Roll over	3-6 months				
Sat alone without support	6-9 months				
Crawling	6-9 months				
Walk Alone	11-15 months				
First Words & Sentences	8-18 months				
Capable of self-feeding	12-15 months				
Toilet Trained (bladder)	2-3 years				
Toilet Trained (bowel)	2-3 years				
Toilet Trained during night	3-4 years				

6. During the first 3 years of life, the child: (check all that apply)

	Frequently	Sometimes	Rarely
Had temper tantrums			
Had extreme mood changes			
Was afraid of new people or places			
Was distractible			
Was unresponsive to discipline			
Was destructive			
Engaged in self-injuring behaviors (e.g. head banging)			
Was very quiet			
Did not like to be touched or held			
Preferred toys over contact with people			
Cried			
Enjoyed being held			
Was alert to what was happening around him/her			
Explored the surrounding environment			
Was active			
Interacted with adults			
Interacted with other children			
Had predictable sleep-wake cycles			
Had predictable bowel/bladder patterns			
Had predictable hunger/appetite patterns			

Sexual Development

1. Has the child sought any sexual information from parents? _____Yes _____No
   If yes, describe nature of questions, how they were handled? ______________________________
   ____
2. Has the child started to develop sexual characteristics? _____Yes _____No
   If yes, age of onset: __________
   For girls: Age of first menstrual period: _________
   Any cramps or physical discomfort: _____Yes _____No
   What is her attitude towards menstruation? ______________________________
3. Has the onset of puberty caused any difficulties for the child? _____Yes _____No
4. Has the child ever behaved or talked in a way that was not appropriate for a boy/girl or his/her age? _____Yes _____No
   If yes, give details about nature of behavior, age at the time, and what was done about it? ________
   ____

MEDICAL HISTORY

1. Name and address of physician or medical group______________________________
2. Last appointment with physician______________________________Reason______________________
3. What is the child's current: Weight? ________________________ Height? ______________________
4. Is the child taking any prescription medications? _____Yes _____No
   If yes, list ____________________ ____________________
   ____________________ ____________________
   ____________________ ____________________
5. Has the child ever been hospitalized? _____Yes _____No
   If yes, please give details: ______________________________
   ____
6. Please list any allergies: ______________________________
7. Health Inventory – Does the child currently display or complain of any of the following symptoms?

√	Symptom	Age	Specify Treatment
	Fever		
	Headaches		
	Dizziness		
	Vision problems		
	Hearing problems		
	Constant cough		
	Asthma		
	Heart murmur		
	Nausea/vomiting		
	Constipation		
	Diarrhea		
	Soiling problems		
	Urination problem		
	Been unconscious		

√	Symptom	Age	Specify Treatment
	Seizures		
	Surgery		
	Muscle Weakness		
	Weight loss		
	Jaundice		
	Sore throat		
	Ear aches		
	Rashes		
	Joint/muscle pain		
	Tics		
	Head injury		
	Other:		
	Other:		

CHEMICAL/ALCOHOL USE/HISTORY

1. Are there any chemical use issues for your child/adolescent? _____Yes _____No

   If yes, check all that apply: _____ Nicotine/cigarettes _____ Diet pills
   _____ Alcohol _____ Speed
   _____ Marijuana _____ LSD/acid/angel dust
   _____ Cocaine/crack _____ Heroin
   _____ Sleeping pills _____ other (please list: ___________)

2. Is there anyone in the family who has an alcohol/chemical problem? _____Yes _____No

   If yes, please explain ______________________________

   ____

3. Has the child/adolescent attended chemical dependency treatment? _____Yes _____No

   If yes, please give details: ______________________________

   ____

FAMILY and LIVING SITUATION INFORMATION

Home Safety

1. Does the child have access to firearms at home? _____ Yes _____No

   If yes, how are firearms secured? ______________________________

2. Does the child feel safe in his/her community/neighborhood? _____Yes _____No

   If no, why not? ______________________________

Parent Info

1. Father:
   Birth Date: ____________________ Birth Place: ____________________
   Religion: ____________________ Ethnic Background: ____________________
   Occupation: ____________________ Place of Employment: ____________________
   Date of Marriage: ____________________ Education: ____________________
   If separated, divorced, widowed, previously married, please specify: ____________________

   ____

   Please describe any problems while growing up, in reference to personal/family problems:
   ____ Sexual Abuse ____ Physical Abuse ____ Emotional Abuse
   ____ Chemical Dependency ____ Family violence ____ Mental Illness
   ____ Criminal behavior ____ Suicide ____ Medical Illness
   ____ Eating Disorders ____ Other: ____________________

2. Mother:
   Birth Date: ____________________ Birth Place: ____________________
   Religion: ____________________ Ethnic Background: ____________________
   Occupation: ____________________ Place of Employment: ____________________
   Date of Marriage: ____________________ Education: ____________________
   If separated, divorced, widowed, previously married, please specify: ____________________

   ____

   Please describe any problems while growing up, in reference to personal/family problems:
   ____ Sexual Abuse ____ Physical Abuse ____ Emotional Abuse
   ____ Chemical Dependency ____ Family violence ____ Mental Illness
   ____ Criminal behavior ____ Suicide ____ Medical Illness
   ____ Eating Disorders ____ Other: ____________________

Parent's Relationship History

1. Current relationship status: ____ Never married ____ Married ____ Separated ____ Divorced
2. Would you describe the relationship as:
   ____ Smooth ____ with occasional difficulties
   ____ Failure ____ with frequent difficulties
3. Are there any legal or physical custody issues? _____Yes _____No

Please explain: ____

____

____

Father's Name: ______________________ Mother's Name: ______________________

If not birth father, list relationship: ______________ If not birth mother, list relationship: ______________

Address: ______________________ Address: ______________________

______________________ ______________________

If not presently living with the child, please give whereabouts of biological mother and/or father:

Father: ______________________ Mother: ______________________

Siblings/Relatives

1. List all children, including those by previous and subsequent relationships, and any deceased children:

Name	Gender	Age	Living in household (yes/no)

2. List any relatives or other people living in the household:

Name	Age	Relationship

3. Are there frequent conflicts between the child and siblings (or others in household)? ___ Yes ___ No

   If yes, please explain: ____

   ____

Basic Needs

1. Are there any concerns relating to the family's financial status? _____Yes _____No

   If yes, please explain: ____

   ____

2. Are the child's basic needs met (housing, clothing, food, etc.)? _____Yes _____No

   If no, specify need not being met: ____

   ____

EDUCATION HISTORY

1. School presently attending: ____________________________ Location: ______________________________
   Current grade: ________________________
2. Child's academic strengths: ____
   ____
3. Child's academic weaknesses/problems:____
   ____
4. Please check problems that apply to the child:

_____ Truancy, unexcused absences (if so, how much school has child missed? ____________________)
_____ Police or Court involvement because of behavior problem
_____ Fighting
_____ Arguing with Teachers
_____ Suspended or Expelled
_____ Stealing
_____ Refusing to do School Work
_____ Poor Peer Relationships

5. Please check what you feel best describes the child/adolescent in the following areas:

	Above Average	Average	Below Average
Grades:	_____	_____	_____
Ability:	_____	_____	_____

6. Does your child receive special education services: _____Yes _____ No
   If yes: please check all that apply:

____ Developmental Delay
____ Visually Impaired
____ Emotional/Behavioral
____ Traumatic Brain Injury
____ Unsure
____ Special Learning Disability
____ Speech/Language
____ Cognitive Disability
____ Other Health Impaired
____ Other: ____________________
____Hearing Impaired
____ Physically Impaired
____ Autism Spectrum
____ Current 504 Plan

7. Has the child repeated any grades? _____Yes _____ No
   If yes, please give details including grade, reasons for repeating, and whether results were beneficial or not? ____
   ____
8. Is there any involvement in any extra-curricular activities? _____Yes _____ No
   If yes: please give details, describe successes/problems: _____________________________________
   ____
9. Do you feel that the school is dealing appropriately with your child's:

Strengths:	_____Yes	_____ No	Comments: ______________________
Problems:	_____Yes	_____ No	Comments: ______________________

EMPLOYMENT HISTORY

1. Is the child old enough to be employed? _____Yes _____ No
   If yes, please give job details:

	Job Description	Name of Employer	Years/Months Employed
Present	______________	______________	______________
	______________	______________	______________
Previous	______________	______________	______________
	______________	______________	______________

RELATIONSHIPS

Peer Relationships – Check all that apply.

_____ is shy or timid	_____ has many friends	_____ prefers older friends
_____ is bossy or controlling	_____ has few friends	_____ prefers younger friends
_____ frequent fights with peers	_____ no friends/loner	_____ usually a leader
_____ usually a follower		

Parent-Child Relationship

1. What activities does the child enjoy with their:
   Father: ________________________________
   Mother: ________________________________
2. In what joint activities does the family engage in? ________________________________
   ____
3. Check which parent usually disciplines and how discipline is carried out?
   ___ Father: ________________________________
   ___ Mother: ________________________________
4. Are there differences between mother and father in regards to discipline? _____Yes _____ No
   If yes, please explain: ________________________________
   ____
5. Does the child prefer one parent over the other? _____Yes _____ No
   If yes, which one and why? ________________________________

Other Relationships

1. Are there any other relationships that are important to the child? _____Yes _____ No
   If yes, please explain: ________________________________

STRENGTHS/RESOURCES

At School:	
At Home:	
In Social Settings:	
Special Interests, Hobbies:	

FAITH/SPIRITUALITY BELIEFS

Please briefly describe the spiritual/faith background of the child's family and its importance in the child's life:________________________________
____

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the last six months.

Your child's name .... Male/Female

Date of birth..

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other youth, for example CD's, games, food	☐	☐	☐
Often loses temper	☐	☐	☐
Would rather be alone than with other youth	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other youth or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other youth	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other youth	☐	☐	☐
Often offers to help others (parents, teachers, children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets along better with adults than with other youth	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees chores or homework through to the end	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

Signature .... Date ....

Mother/Father/Other (please specify:)

Thank you very much for your help

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