RETURNING CHILD AND ADOLESCENT 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

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

MEDICAL INFORMATION

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's Relationship

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 INFORMATION

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 _____ Stealing
_____ Arguing with Teachers _____ Refusing to do School Work
_____ Suspended or Expelled _____ 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 _____ Special Learning Disability _____ Hearing Impaired
_____ Visually Impaired _____ Speech/Language _____ Physically Impaired
_____ Emotional/Behavioral _____ Cognitive Disability _____ Autism Spectrum
_____ Traumatic Brain Injury _____ Other Health Impaired _____ Current 504 Plan
_____ Unsure _____ Other: _____

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 INFORMATION

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	_____	_____	_____
	_____	_____	_____

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