HDC
Human Development Center
Comprehensive Behavioral Healthcare
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CCBHC OUTPATIENT QUESTIONNAIRE—(Infant to 5)

**** Please Use Black Ink to Complete**

Thank you for your help in completing this questionnaire about your child. The information is necessary for our clinicians to gain a complete understanding of your concerns. If you have any questions about the form, please check with the front desk or clinician.

IDENTIFYING INFORMATION:

Child's Name: _____ **Today's Date**: _____

Date of Birth:_____

Form Completed By: _____ **Relation to Child**:_____

REASON FOR APPOINTMENT:

Briefly—What are your main issues and concerns?_____
_____
_____

Did someone refer you? ____No _____Yes (who & why?) _____
_____

What are your goals for therapy? What do you hope will change?_____
_____
_____

PARENTS:

	Name	Age	Occupation
Parent			
Parent			
Step-Parent			
Step-Parent			

Parents Marital Status: ____ Married ____ Widowed ____Divorced ____Single ____Partnered

Who has legal custody? _____

If shared physical custody, what is the arrangement: _____

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LIVING SITUATION:

____Own Home ____Rent House ____Rent Apartment ____ Shelter ____ Homeless ____With Others in Their Home

Others living with your child:

Name	Age	Relationship	Occupation/Grade	Quality of Relationship

Pets: _____

FUNCTIONING

B1. How would you rate your child's overall health right now? Please check one.

How would you rate your overall health right now?

____ Excellent
____ Very Good
____ Good
____ Don't Know
____ Fair
____ Poor
____ Refused

B2. In order to provide the best possible mental health and related services, we need to know what you think about how well your child was able to deal with everyday life during the past 30 days. Please indicate your disagreement/agreement with each of the following statements.

Statement	**Response Options**						
During the last 30 days	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Refused	N/A
a. My child is handling daily life							
b. My child gets along with family members.							
c. My child gets along with friends and other people.							
d. My child is doing well in school and/or work.							
e. My child is able to cope when things go wrong.							
f. I am satisfied with our family right							

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now.							

Sleep

Check if applies		Describe, including how often and how long it has been a problem
	Problems falling asleep	
	Problems staying asleep	
	Nightmares	
	Difficulty getting up	
	Other	

How many hours of sleep does your child typically get a night? _____
What time is their bedtime during the week?_____ When do they usually get up?_____
Is it different on weekends? No _____ Yes _____ If yes, how so?_____
Do they fall asleep by themselves or with someone else?_____

Eating

Check if applies		Describe, including how often and how long it has been a problem
	Made comments about needing to lose weight or being fat	
	Is dieting	
	Appetite/Weight changes	
	Hoards/Hides/Sneaks food	
	Other	

Mood

Check if applies		Describe, including how often and how long it has been a problem
	Lacks interest in activities they use to enjoy	
	Is not curious about their environment	
	Changed level of	

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	activity	
	Socially withdrawn	
	Fatigue	
	Tearfulness/Cries easily	
	Sadness	
	Depression	
	Morbid Thoughts (talking about death)	
	Self-Harming Behavior (cutting, erasing self, punching walls, etc)	
	Mood swings/emotional lability (fine one minute, mad/sad the next)	
	Easily Irritated	
	Other	

Behavior and Attention

Check if applies		Describe, including how often and how long it has been a problem
	Concentration Problems	
	Having too much energy	
	Focus too much (in their own world)	
	Doesn't notice when they make mistakes	
	Distracts/Annoys others	
	Bullies others	
	Is bullied	
	Has difficulty following directions	
	Aggressive behavior	

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	Lies/omits information/does not tell the truth	
	Takes things that do not belong to them	
	Running away	
	Difficulty with transitions	
	Impulse control	
	Fire setting	
	Mean to animals	
	Inappropriately touches own private parts	
	Touches other children's private parts	
	Gets stuck or perseverates on certain things	
	Overly friendly with strangers	
	Poor judgment about safety	
	Destroys own/others' possessions	

Anxiety

Check if applies		Describe, including how often and how long it has been a problem
	Worries	
	Fearfulness	
	Excessive shyness	
	Difficulty separating from certain adults	
	Clingy	
	Social Fear	

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	Withdrawn	
	Unassertive	
	Stomach aches/Headaches/other body pains	
	Flashbacks/intrusive thoughts	
	School refusal	
	Hypervigilance	
	Startles easily	
	Other	

Self Regulation

Check if applies		Describe, including how often and how long it has been a problem
	Temper tantrums	
	Difficulty calming down/soothing self	
	Bangs head	
	Hurts self when upset	
	Cannot be soothed by others	
	Does not seek out caregivers for help	
	Avoids eye contact	
	Does not seek out parent as a source of comfort	
	Engages in reciprocal play	

When was your child potty trained? Bladder_____ Bowel_____

Check if applies		Describe, including how often and how long it has been a problem
	Daytime Wetting	
	Nighttime Wetting	
	Soiling Themselves	
	Playing with Feces	

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Any other symptoms or issues that you think would be helpful for us to know about?

_____
_____
_____

FUNCTIONING DIFFICULTIES:

Do your child's emotional or behavioral issues or concerns interfere with their ability to function in the following areas of their life?

Check if Yes		Describe	Check if Yes		Describe
	Home Life			Taking Care of Personal Needs/Self Care	
	Family Relationships			Leisure Activities	
	School			Employment	
	Friendships			Getting Along with Others	
	Physical Activity				

Describe your child's strengths, talents and/or interests?_____
_____
_____

MENTAL HEALTH HISTORY:

Has your child ever been diagnosed with a mental illness/mental health problem?
_____No_____Yes (list)_____

Have you had previous mental health services? If so, when? By whom?

Psychiatric care_____
Psychotherapy _____
Partial hospitalization program_____
Psychological testing_____
Other: _____

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Does your child have current mental health providers (Psychiatrist, Psychiatric NP, therapist, case manager, CTSS worker)?
_____No _____Yes (who?) _____

Is your child currently taking medication for mental health symptoms?
_____No _____Yes: ((List the medication and dosage or bring a current medication list) _____
_____

MEDICAL HISTORY:
Primary Care Physician: _____ Location:_____
Date of Last Well Child Visit: _____
Date of Last Dental Visit: _____

Has your child had any prior surgeries? ____No ____Yes (what and when)_____
_____

Has your child any been hospitalized for any reason? ____No ____ Yes (what and when)_____
_____

Current Medications (dosage or bring a current medication list): _____
_____

Past Medications: _____

Allergies: _____

Does your child often complain of pain? _____No _____Yes (describe) _____

FAMILY HISTORY:
Are there any relatives of the child (including parents, grandparents, aunts, uncles or cousins who have any of the following conditions?

	Relationship		**Relationship**
ADHD		Autism/Asperger's	
Alcohol or Drug Problems		Anxiety/OCD	
Brain Damage		Bipolar Disorder/ Manic Depression	
Chronic Pain		Convulsions/Seizures	
Depression		Developmental Delays	
Domestic Violence		Eating Disorder	

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Learning Disorders		Mental Health Hospitalizations	
Nerve Problems		Personality Disorder	
Physical Abuse		PTSD	
Schizophrenia		School Problems	
Sexual Abuse		Suicide Attempts	
Tic or Tourette's Disorder		Other	

FAMILY STRUCTURE:

	Name	**Age**	**Where do they live? (city, state)**	**What is their relationship like with your child?**
Grandparents:				
Aunts and Uncles				
Siblings not living at home				

Who are the other important people in your child's life?(i.e. relatives, mentors, coaches, family friends, etc)_____
_____

How does your child get along with your extended family or adult friends?_____
_____

DEVELOPMENTAL HISTORY: (If the person completing this form is not a biological parent, please complete the following section to the best of your ability):

Where was your child born?_____

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What was your reaction to finding out that you were pregnant with your child? _____
_____

What was your relationship status when you found out you were pregnant?_____
_____

What was the pregnancy with your child like?_____

Prenatal care: ____ Regular ____ Intermittent ____ None _____ Other: _____
Was your child exposed to any substances during pregnancy or prior to learning you were pregnant?
_____No _____prescribed drugs _____street drugs _____tobacco _____ alcohol
Did you have any medical issues or sources of extreme stress during pregnancy? _____ No _____ Yes (Describe) _____
_____

Describe the delivery:
_____Vaginal _____C-section _____Uncomplicated
_____Premature (how early?) _____
_____Postmature_____
_____Complicated (describe) _____

How was the delivery/birth experience?_____
Term in weeks: _____ Birth weight: _____
Mother's age at child's birth: _____ Father's age at child's birth: _____
Did you or your child stay in the hospital for an extended period of time? _____No _____Yes (describe) _____
_____
Describe any challenges during infancy (i.e. maternal depression, financial stress, frequent moves).
_____
Describe what your child was like to care for as an infant (i.e. easy, difficult, enjoyable, colicky, fussy)
_____
Early feeding process: _____breastfeed _____bottle fed
Describe feeding process: (i.e. pleasurable, difficult) _____

Your child current temperament:

- _____**Easy or flexible** children are generally calm, happy, regular in sleeping and eating habits, adaptable and not easily upset.
- _____**Difficult, active, or feisty** children are often fussy, irregular in feeding and sleeping habits, fearful of new people and situations, easily upset by noise and commotion, high strung, and intense in their reactions.
- _____**Slow to warm up or cautious** children are relatively inactive and fussy, tend to withdraw or to react negatively to new situations, but their reactions gradually become more positive with continuous exposure.

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Milestone	Age	Other information
Social smiling		
Babbling		
Sit without support		
Distress when separating from caregivers		
Crawl		
Walk		
Slept through night		
Ate solid food		
First word		
Play interactive games (i.e. peek-a-boo)		
First Sentence		
Potty Trained—dry during day		
Dry at night		
Dress without help		

Where has your child lived?	Age of Move	Reason for Move
Born:		

EDUCATIONAL HISTORY:
SCHOOLS ATTENDED

	School	Comments
Daycare		
Preschool		
Kindergarten		
1st Grade		

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Does your child have learning, social or behavior problems at school?
_____No _____Yes (describe) _____

Does/has your child receive any special educational services (IEP, 504, Title 1) or have special educational needs?
_____No _____Yes (describe) _____

SOCIAL HISTORY:
Has your child ever had any prior social service involvement?
_____No _____Yes (when) _____(where) _____

Has your child been in foster placement?
_____ No _____ Yes (when and why)_____

CULTURAL ISSUES:
Is your child actively involved in church, religious activities or cultural activities?
_____No _____Yes (describe) _____
_____

How would you describe your family's income? _____low _____ middle _____ high

How would you describe your child's race/ethnic heritage? _____

Are there any family or friends you would like involved in your child's care in the future?
_____
_____

Is there any additional important information that you want us to know about your child?
_____
_____
_____

Thank you for taking the time to complete this questionnaire.

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