GRAND OAKS
BEHAVIORAL HEALTH

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1800 Hollister Drive, Suite 201
Libertyville, IL 60048-5263

Northbrook Office:
3000 Dundee Road, Suite 111
Northbrook, IL 60062

CHILD/ADOLESCENT INITIAL ASSESSMENT AND DEVELOPMENTAL QUESTIONNAIRE

Patient

Patient's Full Name: Date Completed:

Date of Birth: Age: Race:

Person Answering Questions

Name

Relationship to child

Address

Home Phone

Referral Information

Why are you seeking help for this child?

How long has problem been present?

Who referred you to our services?

Parents

Mother's Name Stepmother? ☐❑ Yes ☐❑ No

Address

Home phone Work phone

Father's Name Stepfather? ☐❑ Yes ☐❑ No

Address

Home phone Work phone

Is this your ❑ biological ❑ adopted ❑ step ❑ foster child?

If adopted, how old was the child when he/she was adopted?

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Does this child have other parent(s) or stepparent(s)? ☐❑ Yes ☐❑ No

If yes, please provide the following information:

Name

Relationship to child Home phone

Name

Relationship to child Home phone

Child's Residence and Home Situation

With what adult(s) does this child live?

How long in current living situation?

Child's Residence (check one): ☐❑ Apartment ☐❑ Single Home ☐❑ Other

How long at current address?

Please provide the following information about individuals living in the home.

Name Age Sex Relationship to this child

Does child have any siblings living outside of the home?

Has child ever experienced any parental separations, divorces, or deaths? ☐❑ Yes ☐❑ No

If yes, when? How old was this child at the time? _____

Please describe the circumstances

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If parents are separated or divorced, who has custody of this child?

How often does the other parent see this child? (Check one)

❑ Weekly or more often ❑ Once or twice a month ❑ Few times a year ❑ Never

Child Care

If family members work outside the home, please provide the following information.

Who cares for this child when family members are at work?

How many hours per day is child in a child-care setting?

How many different people care for this child? (Please explain)

Family Relations

How does this child get along with brother(s) and/or sister(s)?

What do you enjoy most about this child?

What do you find most difficult about raising this child?

What level of education do you hope this child will complete? (Check one)

❑ High School ❑ Technical or vocational school ❑ College ❑ Law, medical, or advanced studies

Who is mainly in charge of discipline in the home?

Do all caregivers agree on discipline?

Describe discipline techniques

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Pregnancy

Was this child a planned pregnancy? ❑ Yes ❑ No

Was the mother under a doctor's care? ❑ Yes ❑ No

Number of previous pregnancies / miscarriages?

Check any of the following complications that occurred during the pregnancy.

❑ Difficulty in conception	❑ Toxemia	❑ Abnormal weight gain
❑ Measles	❑ Excessive Vomiting	❑ German measles
❑ Excessive swelling	❑ Emotional problems	❑ Vaginal bleeding
❑ Flu	❑ Anemia	❑ High blood pressure

❑ Other (Rh incompatibility, etc.)

❑ Maternal Injury: Describe

❑ Hospitalization during pregnancy: Reason

❑ X-rays during pregnancy: What month?

❑ Medications used during pregnancy: What kind?

❑ Alcohol used during pregnancy: Frequency?

❑ Cigarettes used during pregnancy: Frequency?

❑ Other drugs used during pregnancy:

Type	Frequency	Prescription
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No

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Birth

At this child's birth what was the mother's age? Father's age?

Was this child born in a hospital? ☐❑ Yes ☐❑ No If no, where?

Length of pregnancy: weeks Birth weight?

Length of Labor: hours Apgar score

Child's condition at birth:

Mother's condition at birth:

Check any of the following complications that occurred during birth.

❑ Forceps used ☐❑ Breech birth ❑ Labor induced ❑ Caesarean delivery

❑ Other delivery complications: Describe

❑ Incubator: How long?

❑ Jaundiced: Bilirubin lights? ☐❑ Yes ☐❑ No If yes, what kind?

❑ Breathing problems right after birth: Describe

❑ Supplemental Oxygen? ❑ Yes ❑ No

Was anesthesia used during delivery? ❑ Yes ❑ No If yes, what kind?

Length of stay in hospital: Mother: days Child: days

Development

At what age did this child first do the following? Please indicate year/month of age.

Sit alone Crawl

Stand alone Speak first words

Walk alone Speak in short sentences

Was this child breast-fed? ☐❑ No ☐❑ Yes When weaned?

Was this child bottle-fed? ☐❑ No ☐❑ Yes When weaned?

When was this child toilet trained? Day: Night:

Did bed-wetting occur after toilet training? ❑ No ☐❑ Yes If yes, until what age?

Did bed-soiling occur after toilet training? ❑ No ☐❑ Yes If yes, until what age?

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Were there any medical reasons for bed-wetting or soiling? ❑ No ❑ Yes If yes, describe

Has this child experienced any of the following problems? If yes, please describe.

Walking difficulty	❑ No	❑ Yes
Unclear speech	❑ No	❑ Yes
Feeding problem	❑ No	❑ Yes
Underweight problem	❑ No	❑ Yes
Overweight problem	❑ No	❑ Yes
Colic	❑ No	❑ Yes
Sleeping problem	❑ No	❑ Yes
Eating Disorder	❑ No	❑ Yes
Difficulty learning to ride a bike	❑ No	❑ Yes
Difficulty learning to skip	❑ No	❑ Yes
Difficulty learning to throw or catch	❑ No	❑ Yes

During the child's first 4 years, were any special problems noted in the following area? If yes, please describe.

Eating	❑ No	❑ Yes
Motor skills	❑ No	❑ Yes
Sleeping too much	❑ No	❑ Yes
Temper tantrums	❑ No	❑ Yes
Sleeping too little	❑ No	❑ Yes
Failure to thrive	❑ No	❑ Yes
Separating from parents	❑ No	❑ Yes
Excessive crying	❑ No	❑ Yes

Which hand does this child use for writing or drawing?

Eating? Other (throwing, etc.)?

Has this child been forced to change writing hand? ❑ No ❑ Yes

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Medical History

Childhood Illnesses / Injuries

Please check the illnesses this child has had and indicate age (year/month).

❑ Head Injury (Describe):

❑ Coma or loss of consciousness (Describe): □

❑ Sustained any high fever (Describe):

❑ Meningitis (Describe) :

❑ Encephalitis (Describe) :

❑ Has this child undergone any type of surgery? (Describe) :

❑ Other (Describe) :

Musculoskeletal

Muscle pain ❑ No □❑ Yes

Clumsy walk ❑ No □❑ Yes

Toe walking ❑ No □❑ Yes

Poor posture ❑ No □❑ Yes

Other muscle problems ❑ No □❑ Yes

Neurological

Seizures / convulsions ❑ No □❑ Yes If yes, describe

Speech defects ❑ No □❑ Yes

Has tics/twitches ❑ No □❑ Yes

Bangs head ❑ No □❑ Yes

Rocks back and forth ❑ No □❑ Yes

Flaps hand ❑ No □❑ Yes

Has this child ever taken medication to decrease activity? ❑ No □❑ Yes

If yes, when? What medication?

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Medical History, continued

Allergies

Allergy to medicine ❑ No ❑❑ Yes If yes, describe:

Allergy to food ❑ No ❑❑ Yes If yes, describe:

Other allergies ❑ No ❑❑ Yes If yes, describe:

Hearing

Ear Infections ❑ No ❑❑ Yes

Hearing Problems ❑ No ❑❑ Yes

Ear Tubes ❑ No ❑❑ Yes

Date of most recent exam ❑ No ❑❑ Yes

Vision

Vision problems ❑ No ❑❑ Yes

Wears glasses or contacts ❑ No ❑❑ Yes

Date of most recent vision exam ❑ No ❑❑ Yes

Medical Care

Child's physician Telephone

Address

How often does this child see a doctor?

Date of last visit?

Is this child currently on medication? ❑ No ❑ Yes If yes, indicate type, reason, and dosage

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Medical History, continued

Family Health

Have any family members had any of the following? If yes, please specify family member's relationship to this child.
If this child is not living with biological parents, please indicate health information on biological parents if known.

❑ Tourette's Syndrome ❑ Alcohol / Drug Abuse

❑ Behavioral Disorder ❑ Emotional Disturbance

❑ Mental Illness ❑ Mental Retardation

❑ Seizures or Epilepsy ❑ Reading Problem

❑ Other Learning Disability ❑ Speech or Language Problem

Educational History

Does or did this child attend preschool? ❑ No ❑❑ Yes

At what age? Amount of time per week? Days per week?

Preschool Name ❑ Regular Education ❑ Special Education

Any problems in preschool? ❑ No ❑❑ Yes If yes, describe:

Does or did this child attend kindergarten? ❑ No ❑❑ Yes

Any problems in kindergarten? ❑ No ❑❑ Yes If yes, describe:

Elementary / High School

Please indicate whether this child has had any of the following school experiences.

Has changed schools for reasons other than normal academic progression? ❑ No ❑ Yes If yes, when and why?

Has been retained a grade in school? ❑ No ❑ Yes If yes, when and why?

Has skipped a grade in school? ❑ No ❑ Yes If yes, when and why?

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Medical History, continued

Elementary / High School, continued

Has difficulty with reading? ❑ No ❑ Yes If yes, when and why?

Has difficulty with math? ❑ No ❑ Yes If yes, when and why?

Gets poor grades? ❑ No ❑ Yes If yes, when and why?

Has been tested for special education? ❑ No ❑ Yes If yes, when and why?

Currently is placed in special education class? ❑ No ❑ Yes If yes, when and why?

Dislikes going to school? ❑ No ❑ Yes If yes, when and why?

Speech and Language

Are there any concerns about your child's: ❑ Speech ❑ Language ❑ Hearing

Describe

Describe how your child makes his/her wants and needs known?

Does your child understand directions? ❑ Yes ❑ No

Describe

Language Spoken at Home

Child's primary language:

Second language:

Language spoken to your child at *home* currently:

Language spoken to your child at *school, babysitters, etc.* currently:

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Developmental Follow-Up

Have you consulted any other specialists about your child's development? *If yes, describe below.

- ❑ Audiology
- ❑ Speech and language
- ❑ Psychologist
- ❑ Psychiatrist
- ❑ Eye Specialist
- ❑ Ear, Nose, Throat Doctor
- ❑ Occupational Therapist
- ❑ Physical Therapist
- ❑ Other: _____

Describe: _____

Visual History *(For school aged children)*

Does your child report or have you noted any of the following:

- ❑ One eye turns in or out, up or down at any time
- ❑ Visual fatigue after visual concentration
- ❑ Excessive tearing of eyes or rubbing eyes frequently
- ❑ Closes or covers one eye in bright light or during visual tasks
- ❑ Avoids close work
- ❑ Uses finger as marker when reading
- ❑ Poor printing or handwriting
- ❑ Difficulty in copying from blackboard to paper
- ❑ Complaints of blurred vision during reading or writing
- ❑ Reports that words are "running together"
- ❑ Skips and rereads words or letters
- ❑ Complains of headaches associated with visual tasks

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Friendships

Please indicate how this child relates to other children.

Has problems relating to or playing with other children ❑ No ❑ Yes

If yes, describe: _____

_____

Fights frequently with playmates / friends ❑ No ❑ Yes _____

Prefers playing with younger children ❑ No ❑ Yes _____

Has difficulty making friends ❑ No ❑ Yes _____

Prefers to play alone ❑ No ❑ Yes _____

Are there children in the neighborhood with whom this child could play? ❑ No ❑ Yes

What role does this child take in peer group games? (e.g., leader, aggressor, follower, etc.)

_____

Recreation/Interests

What activities does this child enjoy?

Sports: _____

_____

_____

Hobbies: _____

_____

_____

Other: _____

_____

_____

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Behavior Temperament

Please indicate whether this child exhibits any of the following behaviors:

Is easily over stimulated in play or activity	❑ Yes	❑ No
Seems overly energetic in play or activity	❑ Yes	❑ No
Has a short attention span	❑ Yes	❑ No
Seems impulsive	❑ Yes	❑ No
Lacks self-control	❑ Yes	❑ No
Overreacts when faced with problem	❑ Yes	❑ No
Seems unhappy most of the time	❑ Yes	❑ No
Hides feelings	❑ Yes	❑ No
Withholds affection	❑ Yes	❑ No
Requires a lot of attention	❑ Yes	❑ No
Seems uncomfortable meeting new people	❑ Yes	❑ No
Has fears	❑ Yes	❑ No

If yes, describe:

What makes this child angry?

Unusual and/or Traumatic Life Events

Please describe any unusual circumstances and/or traumatic family events in this child's life, which you feel may have affected his or her development and ability to function (for example, birth of a sibling, deaths in the family, divorce, illnesses, frequent school changes, moves, accidents, etc.).

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Additional Comments

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