LOWCOUNTRY PSYCHIATRIC GROUP

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Child and Adolescent Clinical Interview Questionnaire

CHILD INFORMATION:

Name: _____ DOB: _____

School: _____ Grade: _____

PARENT INFORMATION:

Name: _____ Name: _____

Age: _____ Age: _____

Occupation: _____ Occupation: _____

Relationship to Child: _____ Relationship to Child: _____

PRESENTING PROBLEM: _____

_____

_____

_____

WHEN DID THE PROBLEM START: _____

_____

_____

Have you recently worried your child may have (please circle any relevant items below):

□ Yes □ No	DEPRESSION (sad, irritable, hopeless, poor sleep, crying, social withdrawal/isolative behaviors, lack of interest in things, etc.)
□ Yes □ No	MOOD SWINGS (energetic, little sleep, pleasure seeking, racing thoughts, too talkative, inappropriate sexual behaviors, grandiose, etc.)
□ Yes □ No	ANXIETY (worries, restless, scared, poor sleep, obsessive thoughts and/or compulsive behaviors, frequent complaining of headaches and/or stomach aches, frequent school absences, etc.)

□ Yes □ No	ATTENTION/HYPERACTIVITY PROBLEM (difficulty sustaining attention, hyperactive, impulsive, distractibility, not completing tasks)
□ Yes □ No	BEHAVIORAL PROBLEM (fights, anger, arguing, truancy, destruction of property, fire setting, etc.)
□ Yes □ No	SOCIAL ANXIETY (shy and/or afraid to be around others)
□ Yes □ No	REMEMBERING PAST TRAUMAS (frequent nightmares, intrusive and/or recurrent memories, etc.)
□ Yes □ No	ABNORMAL EATING BEHAVIORS (too much, too little, fear of weight gain, distorted body image, over exercising, etc.)
□ Yes □ No	AUTISM (social and language impairments, rigidity)
□ Yes □ No	DISSOCIATION (feeling outside your body or things are not real, etc.)
□ Yes □ No	PSYCHOSIS (hearing voices, seeing things, paranoia, delusions)

FAMILY INFORMATION:

Siblings: _____

_____

Family members living in the home: _____

_____

Child's relationship with family members: _____

_____

History of mental illness in family (e.g., depression, anxiety, ADHD, learning disabilities, etc.)

_____

_____

Major medical illnesses in family: _____

_____

Additional family history (e.g., substance abuse, legal problems, domestic violence, etc.):

_____

_____

DEVELOPMENTAL HISTORY:

Any prenatal complications: _____

Birth history (e.g., full-term, birth weight, birth difficulties, etc.): _____

_____

Developmental Milestones:

Age when sat up alone: _____ Age when crawled: _____

Age when walked: _____ Age when spoke first word: _____

Age when used complete sentence: _____ Age when toilet trained: _____

Medical History:

Any serious accidents, head injuries, hospitalizations, surgeries, etc.: _____

_____

_____

_____

Concerns about hearing, vision, dental care: _____

_____

_____

Medication History:

Medication	Dosage	Duration

EDUCATIONAL HISTORY:

Age first started school/daycare: _____

Repeated any grades: _____

Type of current classes (e.g., regular education, honors, special education, etc.):

_____

Current grades: _____

Any after school activities (e.g., clubs, sports, groups): _____

_____

PREVIOUS TREATMENT:

Ever seen counselor, therapist, psychiatrist (if yes): _____

_____

Age when saw: _____

Name/title/phone number of professional: _____

Type/length of treatment: _____