

**BACKGROUND QUESTIONNAIRE**

**Please take a moment to read and fill out the following questions. The information that you provide is an important step in the psychological evaluation process and allows me to better serve you and your child.**

**FAMILY DATA**

Child's name: \_\_\_\_\_ Today's date: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex (circle one) Male Female  
County of residence: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_  
Person filling out this form (circle one): Mother Father Stepmother Stepfather Grandparent  
Other (please explain): \_\_\_\_\_

Parents are currently: \_\_\_ Married \_\_\_ Divorced \_\_\_ Remarried \_\_\_ Never married  
Child's custodian/guardian (Name) \_\_\_\_\_ Relation to child: \_\_\_\_\_  
If parents are divorced, please describe custody/visitation arrangement: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mother's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Address (if different from child): \_\_\_\_\_  
Currently employed: \_\_\_ No \_\_\_ Yes, as: \_\_\_\_\_ Work phone: \_\_\_\_\_

Father's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Address (if different from child): \_\_\_\_\_  
Currently employed: \_\_\_ No \_\_\_ Yes, as: \_\_\_\_\_ Work phone: \_\_\_\_\_

Stepparent's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Address (if different from child): \_\_\_\_\_  
Currently employed: \_\_\_ No \_\_\_ Yes, as: \_\_\_\_\_ Work phone: \_\_\_\_\_

List all people currently living in household:

<u>Name</u>	<u>Relationship to Child</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If any brothers or sisters are living outside the home, list their names and ages: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PSYCHIATRIC FAMILY GENETIC HISTORY QUESTIONNAIRE

**BACKGROUND:** As a group, psychiatric disorders (or emotional and behavioral problems in kids) have a relatively high heritability. This means that genetics is a major factor in the development of these problems and illnesses. A careful assessment of the family history of these problems is quite helpful in diagnosis and treatment planning. With the human genome project now completed and ever more information available about genetics, this family history information is becoming increasingly important. A family history of problems suggests the presence of genetic risk. Remember, genetic risk increases the probability of developing a similar or related problem, but genes are not destiny. Many other factors (including we hope, early recognition and treatment) play an important role in whether a problem will develop and at what level of severity.

**GENERAL DIRECTIONS:** This is a lengthy and somewhat complicated questionnaire, but please hang in there and take it step by step since it is quite important. For a genetic history we are considering “blood relatives” (not the foster or adoptive family). You can greatly increase how accurate and complete this information is by making sure to follow these proven principles:

- a) get information from more than one family member on both the mother’s and father’s sides
- b) first identify all close relatives by name and age
- c) take time to carefully consider each and every close relative for each kind of problem, and
- d) include whatever information you have

An adult patient will typically complete this history themselves, consulting members from both sides of their family. For a child, the parent will complete it. The parent most familiar with that side of the family history should complete the information (i.e., this might mean the mother would complete the mother’s side, and the father the father’s side, unless the mother is the family member who actually knows more for both sides, or if only one parent is available) Read all the directions for Step A, and then complete it. Next, read all the items for Step B and complete it. Take a quick look now at the accompanying “Recording Form” you will use to record the information.

**STEP A:** Listing ALL the close relatives (simpler than it looks).

1. Write in who completed the **mother’s side** history (e.g., Mom-Julie), and circle yes or no regarding whether other family members were consulted (hopefully yes!).
2. Write the patient’s mother’s first name and age (for parents completing this form, remember, this is *not your mother*, but the child’s) For age, if the person is 20 or older, simply write the decade of life (e.g., 40s), if younger than 20, then write your best estimate of the age.
3. Then write the first names of the patient’s grandmother and grandfather and their ages (again, for parents or guardians of the patient, this is *not your grandmother*).
4. If someone is deceased, write the age at which they had died (e.g., 50s), and draw a light diagonal line through the age.
5. Next write down **all** maternal (mother’s blood relatives) aunts and uncles first names (do not include half aunts/uncles).
6. Write down **all** brothers and sisters (listed as “siblings”). Include half-siblings, and put ½ after the word “sibling”. For siblings, indicate if they are male (m) or female (f) after their age (e.g., 14f). Your child’s siblings need not be duplicated in the mother’s and father’s list, but half siblings would appear on one side or the other. If the patient has children, these can be listed in the “Other” section or on the back.
7. Now repeat all the above steps for the patient’s **father’s side** (again, for parents of the patient completing this form, make sure to *list relatives based on their relationship to the patient/child*).

**Step B:** Listing the family history.

1. Carefully read through the list of problems on the next page.
2. Have a conversation with one or two members on the mother’s side of the family to gather information.
3. Start at the top with the mother’s side (the patient’s mother) and systematically go through each person. Think about all you know about this person, and then deliberately go through each item on the problem list to consider whether each of the problems is present in that person’s history.
4. Each time the problem is present, indicate that by writing the “code” (the bold face letters) on the line following the person’s age. Write as many problems as are present (e.g., **hosp. suid. diag. med. drug**).
5. On the full line below the family member’s name, write additional details or information (e.g., **hosp. in 20s, bipolar, suicide attempt, lithium, marijuana**). Use the back of the paper to add more details if available.
6. Now repeat these steps with the father’s side.
7. Celebrate, you’ve finished! Keep a copy for yourself.

## Problem List

(Please remember to consider each of these questions for each of the close relatives)

1. Has this relative ever been **hospitalized** for psychiatric or substance abuse problems?
2. Has this relative ever made **suicidal** statements or had suicidal behavior?
3. Has this relative ever had clearly bizarre/**psychotic** behavior or thinking, hallucinations, or very strange untrue beliefs (delusions)?
4. Has this relative ever been treated with **medications** for a psychiatric or emotional/behavioral problem (e.g., medicine for depression, anxiety, or hallucinations)? If known, write the name of the medicine.
5. Has this relative ever had a **diagnosis** for a psychiatric or emotional/behavioral problem? This would include problems such as depression, mania, bipolar disorder, anxiety, ADHD/hyperactivity, schizophrenia, tic disorders, panic disorder, enuresis, etc.
6. Has this relative ever had persistent moodiness or rapid emotional or mood **swings** that caused very serious problems?
7. Has this relative ever had **criminal** behavior involving the police or courts (include if this was in the juvenile justice system)?
8. Has this relative ever had an **alcohol** abuse problem?
9. Has this relative ever had a **drug** abuse problem?
10. Has this relative ever had problems with recurrent **aggression**, violence, or serious explosive anger?
11. Has this relative ever had problems with **learning** or a learning disorder (e.g., reading disorder or dyslexia)?
12. Has this relative ever had problems with a **developmental** disorder (e.g., mental retardation or autism-like problems)?
13. Has this relative ever had problems with a known **genetic** disorder that runs in the family?

## Family Genetic History Recording Form

Patient's First and Last Name, Age, and Gender: \_\_\_\_\_

**MOTHER'S Side:** Completed by: \_\_\_\_\_ Consulted others: Yes or No

<u>Relationship to Child</u>	<u>First Name</u>	<u>Age</u>	<u>History</u>
Mother	_____	_____	_____
Grandmother	_____	_____	_____
Grandfather	_____	_____	_____
Aunt/Uncle	_____	_____	_____
Aunt/Uncle	_____	_____	_____
Aunt/Uncle	_____	_____	_____
Oldest Child/Sibling	_____	_____	_____
Next Child/Sibling	_____	_____	_____
Next Child/Sibling	_____	_____	_____
Other: _____	_____	_____	_____

**FATHER'S Side:** Completed by \_\_\_\_\_ Consulted Others: Yes or No

<u>Relationship to Child</u>	<u>First Name</u>	<u>Age</u>	<u>History</u>
Father	_____	_____	_____
Grandmother	_____	_____	_____
Grandfather	_____	_____	_____
Aunt/Uncle	_____	_____	_____
Aunt/Uncle	_____	_____	_____
Aunt/Uncle	_____	_____	_____
Oldest Child/Sibling	_____	_____	_____
Next Child/Sibling	_____	_____	_____
Next Child/Sibling	_____	_____	_____
Other: _____	_____	_____	_____

## DEVELOPMENTAL HISTORY

Please fill in any of the information you have on the areas listed below.

During pregnancy, was mother on medications Yes \_\_\_\_ No \_\_\_\_  
 If yes, what kind? \_\_\_\_\_

During pregnancy, did mother smoke? Yes \_\_\_\_ No \_\_\_\_  
 If yes, how many cigarettes each day? \_\_\_\_\_

During pregnancy, did mother drink alcoholic beverages? Yes \_\_\_\_ No \_\_\_\_  
 If yes, what did she drink? \_\_\_\_\_  
 Approximately how much alcohol was consumed each day? \_\_\_\_\_

During pregnancy, did mother use drugs? Yes \_\_\_\_ No \_\_\_\_  
 If yes, what kind? \_\_\_\_\_

Was the child premature? Yes \_\_\_\_ No \_\_\_\_  
 If so, by how many months? \_\_\_\_\_ Weight and height at birth? \_\_\_\_\_

Any birth complications or problems? Yes \_\_\_\_ No \_\_\_\_  
 If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

Were there any feeding problems? Yes \_\_\_\_ No \_\_\_\_  
 If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

Were there any sleeping problems? Yes \_\_\_\_ No \_\_\_\_  
 If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age, but have some idea, write the age followed by a question mark. If you do not know or do not remember the age at which the behavior occurred, please write a question mark.

<u>Behavior</u>	<u>Age</u>	<u>Behavior</u>	<u>Age</u>
Showed response to mother	___	Put several words together	___
Rolled over	___	Dressed self	___
Sat alone	___	Became toilet trained	___
Crawled	___	Stayed dry at night	___
Walked alone	___	Fed self	___
Babbled	___	Rode tricycle	___
Spoke first word	___		

Were there any other problems in the growth and development of the child during the first few years?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## **SOCIAL, PEER, AND EDUCATIONAL HISTORY**

Place a check mark next to any behavior or problems you child currently exhibits.

- |   |  |
|---|--|
| <p><input type="checkbox"/> Inability to make/keep friends<br/><input type="checkbox"/> Little or no interest in peer relationships<br/><input type="checkbox"/> Prefers younger or older children<br/><input type="checkbox"/> Aggressive toward other children<br/><input type="checkbox"/> Does not get along well with siblings<br/><input type="checkbox"/> Seems more interested in things (e.g., objects, games, computer) than in people<br/><input type="checkbox"/> Is shy or timid</p> | <p><input type="checkbox"/> Frequently disobeys adults<br/><input type="checkbox"/> Aggressive toward adults<br/><input type="checkbox"/> Disruptive in classroom<br/><input type="checkbox"/> Does not get along well with teachers<br/><input type="checkbox"/> Frequently removed from classroom for behavior problems<br/><input type="checkbox"/> Refused to go to school</p> |
|---|--|

- |  |  |
|--|--|
| <p><input type="checkbox"/> Has difficulty with reading<br/><input type="checkbox"/> Has difficulty with arithmetic<br/><input type="checkbox"/> Has difficulty with spelling<br/><input type="checkbox"/> Has difficulty with writing</p> | <p><input type="checkbox"/> Has difficulty with other subjects (please list)<br/>_____<br/>_____</p> |
|--|--|

Has an identified learning disability (if yes, please describe):  
\_\_\_\_\_  
\_\_\_\_\_

Is in a special education class (If yes, please describe):  
\_\_\_\_\_  
\_\_\_\_\_

Has been held back in a grade (if yes, what grade and why):  
\_\_\_\_\_  
\_\_\_\_\_

Has received special tutoring or counseling in school (if yes, please describe):  
\_\_\_\_\_  
\_\_\_\_\_

### **GENERAL MEDICAL HISTORY**

How is your child's general health currently? Excellent  Good  Fair  Poor  Explain: \_\_\_\_\_  
\_\_\_\_\_

Have there been concerns about growth or weight? No  Yes  Explain: \_\_\_\_\_  
\_\_\_\_\_

Any problems with vision or hearing? No  Yes  Explain: \_\_\_\_\_  
\_\_\_\_\_

Any serious chronic illnesses now or in the past? No  Yes  Explain: \_\_\_\_\_  
\_\_\_\_\_

Please list any overnight hospitalizations (with reasons and age)? \_\_\_\_\_  
\_\_\_\_\_

Any surgeries (for what and at what age); any continuing related problems? No  Yes  Explain: \_\_\_\_\_  
\_\_\_\_\_

Serious injuries? No  Yes  Explain: \_\_\_\_\_

Allergies to medicine or serious allergies? No  Yes  Explain: \_\_\_\_\_

When was the last complete physician examination: Month/year: \_\_\_\_\_ Were there any problems identified? No  Yes  Explain: \_\_\_\_\_

Any special dietary requirements? No  Yes  Explain: \_\_\_\_\_

Immunizations up to date? No  Yes  Explain: \_\_\_\_\_

Has your child had any of the following (please give details):

head injuries: No  Yes  Explain: \_\_\_\_\_

episodes of loss of consciousness: No  Yes  Explain: \_\_\_\_\_

current problems with sleep: No  Yes  Explain: \_\_\_\_\_

seizures: No  Yes  Explain: \_\_\_\_\_

recurrent headaches: No  Yes  Explain: \_\_\_\_\_

abnormal movements, tics, or tremors: No  Yes  Explain: \_\_\_\_\_

change in sensation: No  Yes  Explain: \_\_\_\_\_

change in movement, coordination, or walking: No  Yes  Explain: \_\_\_\_\_

change in speech: No  Yes  Explain: \_\_\_\_\_

recurrent ear infections: No  Yes  Explain: \_\_\_\_\_

changes in weight or concern about eating problems or disorders (e.g., anorexia): No  Yes   
Explain: \_\_\_\_\_

persistent fatigue or fevers: No  Yes  Explain: \_\_\_\_\_

skin changes: No  Yes  Explain: \_\_\_\_\_

breathing or lung problems: No  Yes  Explain: \_\_\_\_\_

heart or blood pressure problems: No  Yes  Explain: \_\_\_\_\_

fainting or irregular heart beat: No  Yes  Explain: \_\_\_\_\_

urination problems or wetting (enuresis): No  Yes  Explain: \_\_\_\_\_

bowel problems or soiling (encopresis): No  Yes  Explain: \_\_\_\_\_

liver injury, infection, or other problems: No  Yes  Explain: \_\_\_\_\_

recurrent nausea, vomiting, or diarrhea: No  Yes  Explain: \_\_\_\_\_

delays or advances in onset of puberty: No  Yes  Explain: \_\_\_\_\_

menstrual problems or sexually transmitted infections: No  Yes  Explain: \_\_\_\_\_

kidney injury, infections, or other problems: No  Yes  Explain: \_\_\_\_\_

problems with bones, muscles, or joints, including recurrent pain: No  Yes  Explain: \_\_\_\_\_

other: No  Yes  Explain: \_\_\_\_\_

Is your child taking herbals, dietary supplements, and/or vitamins No  Yes   
Please list the supplements and amount taken: \_\_\_\_\_

Is your child taking any regular medications (include nonprescription)? No  Yes

Please list the medication and current dose: \_\_\_\_\_