



Comprehensive Neurodevelopmental History and Interview

CNHI, Version 2-2012 with Domains Model © Bluestem Center

The information you provide on these pages is an extremely valuable part of our evaluation of your child. Please complete each item with careful consideration before our first office visit. This information will be part of your child's medical record, and is protected under Privacy Acts. Thank you for your assistance.

General Information

Child's Name _____ Date _____

Child's Current Address _____

City _____ County _____ State _____ Zip _____

Child's Date of Birth _____ Age _____ Sex: Female Male

School _____ City _____

Grade level _____

Child's Ethnic Heritage _____

Who is completing this form? _____

Relationship to Patient _____

Parent/Guardian Name(s) _____

If the child is not currently living with parents, please list the responsible party (group home, foster home, etc.) and who has custody: _____

Phone Numbers (Please circle the preferred contact number)

Home: _____

Mother's Cell: _____ Mother's Work: _____

Father's Cell: _____ Father's Work: _____

Other responsible party: _____

Name and contact information for Non-custodial parents (if any): _____

May we share information freely with the non-custodial parent? Yes No

Email address/es: _____

We will use your email, with your permission as a means of communication.

This evaluation is for (check all that apply):

- First-time evaluation Second opinion
- Updated evaluation Diagnosis
- Transfer care from _____
- Consider medication for _____

How did you learn about Bluestem? _____

Should a copy of our report be sent to another professional? Yes No
Name and Contact Information of the professional who should receive the report:

What are your main concerns about the child at this time? (What's wrong?)

What are some of this child's strengths, positive points, abilities, etc.? _____

Is your child athletically, artistically or musically gifted? _____

What help are you seeking from Bluestem Center? _____

Is the child currently taking any medicine? If yes, please list name and amounts and include vitamins and supplements:

Is the child currently working with another professional for these problems, or have they seen another professional in the past? If yes, please list name and contact information:
Child's Therapist/Counselor: _____
Family Therapist or Parent Coach: _____
Doctor or Psychiatrist: _____
Childrens Mental Health case Manager: _____
Other Services (FEFRA,OT): _____

Has the child been hospitalized for this problem? If yes, please list the hospital and dates: _____

Has the child ever been placed in foster care? _____

Are there any particular pressures or stresses on the child or the family at this time? _____

Current Household and Support System

1. Where does the child live now?

- House in town Apartment House in the country
 Farm Mobile home Temporary housing
 Other _____

2. With whom does the child live now? If the child has more than one home where he/she regularly lives, please list the members of that household also.

Name	Relationship	Age

3. Are there pets in or about the home? Yes No
If yes, list: _____

4. Please list family members not living in the home:

Name	Relationship	Age	Living where

Please bring a copy of divorce/custody decision to your child's evaluation

5. The child's biological parents are: Married Separated Divorced
 Living together Never Married

If relevant, please describe custody/visitation arrangements:

Parents' education and employment:

For education, list "HS" if completed high school, or list highest degree or certificate.
Please list main occupation, even if currently unemployed or not working in that field.

Education Occupation Employer Employment Status (disabled/unemployed)

Biological Mother: _____

Biological Father: _____

Step-mother: _____

Step-father: _____

Does the family belong to a worshipping community? Yes No

If yes, please name: _____

Does the patient attend Regularly Occasionally Rarely

Does the child attend a youth group? Yes No

If not a member/part of a worshipping community what belief systems does the family have? _____

Please list any family activities or hobbies that are enjoyed together (for example, camping, bike riding, science fiction movies...) _____

Are there relatives or others who are regularly involved in caring for the child?

Yes No

Please list: _____

How often does the child visit or stay with them? _____

Has the child ever received respite care? Yes No

If yes, how often: _____

Prenatal History

1. Is the patient adopted? Yes No If yes, at what age? _____
Reason for adoption: _____

Country of origin: _____

2. Mother's health during this pregnancy was: Good Fair Poor Unknown

At how many weeks/months found out was pregnant? ____ wks. ____ mos.

Pre-natal care by a doctor began at about what month? _____

Were there any problems, complications or accidents during this pregnancy?

Was this pregnancy planned: Yes No

3. Parents' age at the time of the patient's birth: Mother _____ Father _____

4. Number of pregnancies before this birth: _____

5. Prior to pregnancy did mother use:

Beer, wine, liquor: Never Once/twice ____ times per day/week/month

Coffee Never Once/twice ____ times per day/week/month

Other caffeine containing drinks (Coke, Pepsi, etc.)

Never Once/twice ____ times per day/week/month

Cigarettes: ____ cigarettes/day _____ packs/day

Did use, change when she realized she was pregnant:

Alcohol Yes No If yes, at what Month: _____

Cigarettes Yes No If yes, at what Month: _____

Coffee Yes No If yes, at what Month: _____

Drugs Yes No If yes, at what Month: _____

Did mother have prenatal care: Yes No Unsure

Medications and supplements used during pregnancy:

Pre-natal vitamins

Prescription Medicines : _____

Non-prescribed Medicines or supplements: _____

6. During the pregnancy did the mother have

Toxemia (high blood pressure) Yes No Unknown

Pre-eclampsia (swelling) Yes No Unknown

Diabetes Yes No Unknown

Rh factor incompatibility Yes No Unknown

X-rays, other possible radiation exposure Yes No Unknown

Accidents, illnesses, surgery Yes No Unknown

Infections, exposures to contagious diseases Yes No Unknown

7. Mother's living situation during the pregnancy: _____

and after delivery: _____

Labor and Birth Information

If labor and birth history is not known, skip to Early Childhood Health and Development.

1. The baby was born: on time _____ weeks early _____ weeks late
2. Birth weight ___ lbs. ___ oz; length _____ in.

APGAR score _____ at 1 minute and _____ at 5 minutes

3. Was the birth induced (made to happen) by a doctor? Yes No Unknown
4. Were there problems or concerns during labor or delivery?

Yes No Unknown

If yes, what? _____

6. How was the baby delivered?

Normal vaginal birth Breech
 Forceps Vacuum extraction
 C-section

If C-section, why? _____

7. Did the baby have any special care after the delivery?

With breathing, oxygen Blood transfusion
 Neo-natal intensive care Infection care; antibiotics
 Seizure care Heart monitoring
 Poor feeding Help to regulate body temperature
 X-rays Drug withdrawal
 Jaundice, bili-lights
 Not very responsive, monitored carefully

Other: _____

8. When did the baby leave the hospital? Next day 2nd day ___ days after birth
9. Where was the baby born? (Hospital name, city, state)

Early Childhood Health and Development (Birth to 18 months)

If this information is not known, skip to the Medical History.

1. How was the baby fed? Breast _____ months Bottle _____ months

2. Please describe any feeding or eating problems. _____

3. Did the baby have colic? Yes No Unknown

4. Did the baby have sleep problems? Yes No Unknown
If yes, describe _____

5. What was the baby's usual temperament or personality?
Excessively active during the pregnancy Yes No Not sure

The baby was:

- Easy - didn't cry much, slept and ate on schedule, cuddly, easy to sooth
- Average – Mostly easy but occasional fussing
- Sensitive - easily upset, best with a fixed schedule
- Difficult - hard to satisfy, fussy, did not eat/sleep on schedule, colicky

Never Some- Often Always
times

6. Describe the child as a baby(< 2 years old):

Likes to point to things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liked to show toys to people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enjoyed being held	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good eye contact, smiling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
"Talking" with you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Played baby games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Describe the child as a toddler:

Select a number on this scale (1-5) to describe where your child falls

Happy and playful	1	2	3	4	5	Irritable, tantrums prone
Confident, made friends easily	1	2	3	4	5	Shy & cautious
Easy to satisfy	1	2	3	4	5	Demanding and fussy
Adaptable, take him/her anywhere	1	2	3	4	5	Upset by change /transition
Always showed feelings intensely	1	2	3	4	5	Hard to know

8. Milestones - When did your child do the following?

	Most children	early	on time	late	don't recall
Rolled over w/o help	4-6mos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	9-12mos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit without support	6-9mos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk without holding on	12-15mos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First words	9-12mos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liked to color	9-12mos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use 2 words together ("Me go")	18-24mos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use a scissors to cut things out	3-6 yrs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tie shoe laces	___yrs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speak in sentences	2-3 yrs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ride a 2-wheeled bike (no training wheels)					
	___yrs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Potty trained during the day/no diapers	2-4yrs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stayed dry at night without diapers	___yrs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Was any part of toilet training very difficult for the child? Yes No

If yes, please explain :

Do you recall your child's first words?

Please comment on any other aspect of your child's early development or recall any stories that tell what your child was like as a toddler: _____

Medical History

1. The child's health is: Excellent Good Fair Problematic

2. Who is the child's medical doctor? _____

Where does she/he work? _____

3. Are the child's immunizations up to date? Yes No Unsure

4. Does the child have any ongoing medical problems for which they see a doctor or take medicine? (Examples: asthma, anemia, diabetes, heart condition, migraine)

Yes No

If yes, what : _____

5. Has your child ever had to stay overnight in the hospital? Yes No

If yes, describe: _____

6. Has your child ever had surgery? Yes No

If yes, describe: _____

7. Does the child have allergies? Yes No

Unsure

If yes, please list: _____

How serious? Potentially life-threatening
 Minor, ongoing problem (dust, cats)
 Occasional problem (hay fever)

8. Check any of the child's reactions to foods, drugs, pollen, grass, animals, chemicals, etc.

Behavior changes Rashes, eczema
 Wheezing Loose bowel movements
 Dark circles under his/her eyes Runny nose, congested

Other : _____

9. Has your child had a bad reaction to any medicines? If yes, please describe:

10. Has the child ever lived in a foreign country? Yes No
If yes, where? _____ At what age? _____

11. Has the family ever lived in an area known for potential problems with lead poisoning or other chemical exposure?
 Lived in a place built before 1950 where lead water pipes and/or lead paint may have been used
 Member of the household worked in a lead industry (auto battery, lead smelter, etc.) or worked with chemicals (herbicides, etc.)
 Played near heavy traffic or where old buildings had been torn down
 Other: _____

12. Are you concerned about your child's eating habits or diet? Yes No
If yes, explain: _____
Are there any foods that the child refuses to eat? _____
Does your child require a special diet? _____

13. Are you concerned about your child's sleep? Yes No
Time goes to/put in bed _____PM
Estimate the time your child actually gets to sleep: _____PM
Time awakens or gets out of bed in the morning: _____AM

Difficulty falling asleep? Yes No
Difficulty staying asleep? Yes No
Difficulty waking up in the morning? Yes No

Does the child do any of these things during sleep?

- Refuses to sleep in his/her bed
- Tosses and turns a lot; bed-covers twisted up in AM
- Complains of leg aches or "growing pains" at night
- Snoring
- Sleeps in unusual positions
- Sweats heavily
- Head banging or body rocking before falling asleep
- Nightmares (tells you about bad dream)
- Night terrors (wakes up screaming; glassy-eyed)
- Grinds teeth
- Sleep-walking
- Watches TV in the bedroom

Other _____

Does your child take naps? Yes No
Does he/she fall asleep during school? Yes No

14. Does your child get regular exercise outside of school? Yes No

- Plays on a sports team
- Takes sports lessons (Example: karate, tennis, golf...)
- Works on a skill alone or with friends (Ex: skateboarding)
- Exercises with a pet (Ex: walks dog, rides horse)
- Active with family or friends

Describe: _____

When active in sports, does your child use head gear or a helmet designed for that sport? Always Sometimes Never

15. Has your child ever had a concussion or brain injury? Yes No
If yes, please describe: _____

16. Does your child wear or use a car seat, restraint, or safety belt?

- Always – never a problem
- He/she takes them off or refuses
- Sometimes it's forgotten

17. Has your child ever had any illness or injuries that required an ER visit, observation, special lab work or x-rays? Yes No
If Yes, please describe: _____

Medical Overview

Please check any of the following conditions that your child has had.
Give the ages when the condition occurred and any additional information.

General

Age and Comments

- Unusual weight gain or loss _____
- Recurrent fevers _____
- Tired or worn out, fatigued _____
- Serious accidents or injuries _____
- Often complains of pains _____
- Worries about health _____
- Frequent infections _____
- Serious illnesses _____

Eyes

- Vision problems, double/blurred/blindness _____
- Eye pain, redness, injury to eye _____
- Uses/needed an eye patch, lazy eye _____
- Wears glasses/contacts _____
- Other _____

Date of last eye exam: _____

Ear, Nose & Throat

- Hearing difficulties _____
- Ringing or itching in ears _____
- Frequent ear infections _____
- Needed ear tubes _____
- Uses a hearing aid _____
- Frequent nose bleeds _____
- Runny nose, congestion _____
- Motions sickness (car, sea, plane) _____
- Sinus infections _____
- Hoarseness, frequent sore throat _____
- Other _____

Date of last hearing exam: _____

Dental

Age and Comments

- Teeth or gum problems _____
- Dry mouth, taste changes _____
- Tends to neglect dental hygiene _____
- Needs/has/had braces _____
- Date of last dental exam: _____

Lungs/Breathing

- Asthma or wheezing _____
- Shortness of breath _____
- Frequent cough _____
- Pneumonia _____
- Turning blue, breath-holding spells _____

Heart & Blood

- High/low blood pressure, fainting spells _____
- Swelling of feet, legs or arms _____
- Heart murmur _____
- "Racing heart," irregular heart beat _____
- Chest pain _____
- Easy bruising _____
- Anemia _____
- Swollen neck glands _____
- Blood clotting disorder _____
- Other _____

Stomach & Bowels

- Frequent vomiting _____
- Frequent diarrhea, constipation, excessive gas _____
- Stomach aches _____
- Soiling underpants after age 4 _____
- Blood in bowel movements _____
- Jaundice (yellowness in eyes) _____
- Heartburn _____
- Lactose intolerance _____

Stomach & Bowels, cont.

- Gluten intolerance _____
- Other _____

Kidneys, Bladder and Genitals

- Bed wetting after age 5 _____
- Daytime wetting after age 4 _____
- Pain when urinating _____
- Bladder infections _____
- Blood in urine, unusual stream _____
- Masturbation problems _____
- Swollen or painful genitals _____
- Bruises or sores on genitals _____
- Girls: age at first period _____
- Vaginal discharge _____
- Irregular menses or heavy menses _____
- Boys: erection/ejaculation problems _____
- Other _____

Nervous System

- Headaches _____
- Knocked out/concussion/stunned _____
- Passing out, fainting _____
- Dizziness, drowsiness, confusion _____
- Weakness, clumsiness, tingling _____
- Muscle spasms, tremors _____
- Tics, twitches, vocalizations _____
- Seizures or "Spells" _____
- Staring spells _____
- Other _____

Glands & Hormones

- Growth problems (height or weight) _____
- Swelling in neck, thyroid problem _____
- Heat or cold intolerance _____
- Warm moist skin; flushed face _____
- Dry coarse skin; dry hair _____

Glands & Hormones, cont.

Age and Comments

- Breast masses, tenderness _____
- Early or late beginning of puberty _____
- Excessive body hair _____
- Excessive sweating, body odor _____
- Other _____

Immune System, Metabolic, Genetic

- Recurrent infections _____
- Infection around the brain _____
- Genetic condition _____
- Blood chemistry condition _____
- Diabetes _____
- Other _____
- Other _____

Muscles, Bones & Joints

- Frequent sprains _____
- Muscle cramps, muscle pain _____
- Restless legs , “growing pains” _____
- Joint pain, arthritis _____
- Broken bones _____
- Hot, red swollen joints _____
- Other _____

Skin

- Warts or fungus _____
- Rashes, lumps, itching, dryness _____
- Serious burns, scalding, scars _____
- Acne requiring a doctor’s care _____
- Changes in nails _____
- Birthmarks _____
- Sore that don’t heal; unusual moles _____
- Tends to neglect body hygiene _____
- Other _____

Other health concerns: _____

Evaluation and Treatment History:

Please bring copies of any evaluations or reports to your child's appointment!

List any previous developmental or mental health evaluations for the child.

Professional, Clinic, or School	When
_____	_____
_____	_____

1. Has the patient had an evaluation, therapy or services for any of the following:

- Development delay
- Occupational or physical therapy
- Sensory integration
- Gross motor problems (coordination, balance)
- Fine motor problems (using a pencil, cutting with scissors)
- Vision problems
- Learning or academic problems/LD
- Speech or language problems
- Hearing problems

2. Has the patient had any counseling or therapy by a psychologist, social worker or Other mental health professional? Yes No

If yes, describe: _____

3. Have you had any counseling, classes, or training by a professional for help with your child's behavior? Yes No

If yes, describe: _____

4. What sources of information have you found about your child's problem?

- Books, magazines
- Friends, family
- School professionals
- TV specials
- Other: _____
- Internet
- Support group
- Health care professionals
- Nothing useful

5. If the child has had medications in the past, check the box and/or circle the name of the medicine.

- Methylphenidate: Concerta, Metadate/CD, Methylin/ER, Ritalin/SR/LA, etc.
- Adderall/XR, mixed amphetamine salts, Dexedrine/Destrostat, Vyvanse
- Antidepressants: Paxil (paroxetine), Prozac (fluoxetine), Zoloft (sertraline), Luvox (fluvoxamine), Celexa(citalopram), Effexor(venlafaxine), Wellbutrin (bupropion).
- Antipsychotics: Zyprexa, Risperdal, Haldol, Mellaril, Orap, Seoquel, Geodon, Abilify
- Mood stabilizers:Lithium, Depakote, Tegretal, Trileptal, Neurontin (gabapentin)
- Clonidine, Tenex (guanfacine), Intuniv
- Strattera (atomoxetine), BuSpar (buspirone)
- Other: _____

School & Education History

1. Where did your child attend day-care or preschool before kindergarten?

Age Where Schedule (example: 8AM - 5 PM, M-F)

Please list the school your child attended, grade, and concerns or important events:

2. **School Name Location Any Issues?**

Kindergarten _____

Kindergarten "Plus" _____

Grade 1 _____

Grade 2 _____

Grade 3 _____

Grade 4 _____

Grade 5 _____

Grade 6 _____

Grade 7 _____

Grade 8 _____

Grade 9 _____

Grade 10 _____

Grade 11 _____

Grade 12 _____

3. Does the child receive any special assistance with schoolwork? Yes No
- Tutoring before or after school
 - Learning disability help
 - DD classroom
 - Alternative program
 - Served under Section 504-Accommodation Plan
 - Enrolled in a special education program; has an IEP
 - Instruction modification/accommodations: daily or weekly assignment sheets, shortened assignments, behavior modification procedures., etc.)
 - Title Reading services
 - Speech/language therapy
 - Emotional/behavioral disorder class
 - After-school study hall

4. Describe any behavior problems while:

- In the classroom
- During recess
- At lunch time
- Riding the bus
- Truancy
- Skipping class

5. Has the child been suspended from school?

- Never
- Once
- A few times
- Can't keep track!

Cause _____

6. Has the child been expelled from school?

If yes, cause _____

7. Has your child been the target of teasing or bullying?

- Never
- Once
- A few times
- Can't keep track!

8. Has your child ever refused to attend school because of worry or stress?

- Never
- Once
- A few times
- Can't keep track!

*Please bring copies of your child's **report cards and any test results** that may be available such as the California Achievement Test (CAT), the Iowa Test of Basic Skills (ITBS), or Minnesota Basic Standards Tests.*

We'd like to review as many years as possible.

If copying is inconvenient, bring them to the appointment and we can copy them in the office.

Social Environment

1. Check any of the following events that may have occurred in the past 12 months:

- Parents divorced or separated
- Family member ill or injured
- Family moved
- Tension in the home
- Legal or financial problems
- Loss of a close friend
- Car accident
- Someone new in the household
- Other major event : _____
- Absence of a parent for 2 or more weeks
- Death in the family
- Death of a pet; acquired a new pet
- Parent changed jobs or lost a job
- Child changed schools or daycare
- House fire, flood, natural disaster
- Family member was a crime victim
- Child saw abuse or sexual situation

Tell us more about these : _____

2. Was the child separated from parents for more than a week before age 6?

- Child hospitalized
- Parent hospitalized
- Parent in prison
- Parent's extended business trip
- Parent separated/divorced
- Parent away to care for someone
- Parent deployed

Other circumstances: _____

3. How easily does the child make friends?

- Worse than average
- Average
- Better than average

4. How long does the child usually keep friendships?

- Not long at all
- Average
- Years

5. How many close friends does he/she have?

- None
- 1
- 2 or 3
- Some
- Lots!

6. My child picks friends who are?:

- "Good kids"
- Bad influences
- Just like him/her
- Needy

7. How well does this child get along with:

- Brothers, sisters Well Average Poorly
- Other kids the same age Well Average Poorly
- Older kids Well Average Poorly
- Younger kids Well Average Poorly
- Teachers Well Average Poorly
- Other adults Well Average Poorly

Caretaker Concerns

1. Check the ways that parents or caretakers deal with behavior problems:

	Mother	Father	Other (who?)
Explaining what's needed	<input type="checkbox"/>	<input type="checkbox"/>	_____
Yelling, screaming	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spanking / pinching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Time out	<input type="checkbox"/>	<input type="checkbox"/>	_____
Taking away privileges	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grounding, restrictions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Giving in to the child	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shunning the child	<input type="checkbox"/>	<input type="checkbox"/>	_____
Point system or chart	<input type="checkbox"/>	<input type="checkbox"/>	_____
1, 2, 3 Magic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Natural consequences	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redirecting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rewards for doing good	<input type="checkbox"/>	<input type="checkbox"/>	_____

2. How well does the child obey after being asked to do something once?

Mother: Never Sometimes Often Always

Father: Never Sometimes Often Always

3. How often does the child eventually comply with the parent's wishes?

Mother: Never Sometimes Often Always

Father: Never Sometimes Often Always

4. Indicate any parenting concerns you have.

- Unsure what is reasonable to expect for age
- Unsure what is reasonable to expect for ability
- Child doesn't seem to care what discipline is used
- "Nothing works."
- You or your spouse lack good parent role models
- Worry about being too strict or too forceful
- Worry about losing control
- Worry about being too easy
- Worry spouse is too strict
- Worry spouse is too nice
- Disagree on expectations
- Disagree with Ex-spouse
- I don't understand my child's behavior
- Concerns about step-parent involvement
- Being consistent

Tell us more?: _____

5. What do you and your child enjoy doing together? _____

Extended Family Psychiatric History:

We will construct a genogram to illustrate the family. Please assist us by listing the parent's relatives. It is helpful for us to know about physical and mental health issues, marital status, and the number of children. If any relatives have problems similar to the child's, please note that. **Please use only first names to conserve confidentiality.** Use the extra space for additional information.

Father's Family	Age	Health/mental health probs	S/M/D/W	# Children
<i>Example:</i> Mrs. Claus	Unknown	Obese/DM (*)	M	None
<i>Example:</i> Luke Skywalker	19?	Healthy	S	None

Mother: _____

Father: _____

Father's Brothers and Sisters:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Mother's Parents and Siblings Age Health/mental health probs S/M/D/W # Children

Mother: _____

Father : _____

Mother's Brothers and Sisters:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Extended Family Psychiatric History, Continued

It's important for us to know whether the child may have inherited a tendency for psychiatric problems. Please look over this list and note on the previous page if any relatives have had these concerns. You may use the abbreviations suggested.

Attention-deficit disorder (with or without hyperactivity) (ADD)

Alcoholism (Alc) (in recovery?)

Autism spectrum (ASD)

Bipolar disorder or Manic-depressive (BiP)

Birth defects/Congenital Anomalies (Cong)

Criminal behavior or conduct disorder (Cond)

Depression (Dep)

Developmental delay or mental retardation (DD)

Drug problems (SA)

Estranged from family (Est)

Gambling/spending (Ga)

Learning problems (LD)

Obsessive compulsive disorder (OCD)

“Odd” or very eccentric (Ecc)

Psychiatric Hospitalization (Hosp)

Schizophrenia (Schiz)

Seizures or epilepsy (SZ)

Socially Avoidant/ loner (loner)

Suicide (+)

Temper problems

Tics/tourettes (T)

Violent or abusive (V)

Worry & anxiety (W & A)

If any blood relatives to the child have had a serious chronic illness, please let us know that also. Examples include: diabetes, thyroid problems, autoimmune disorder, rheumatoid arthritis, Crohn's disease, cancer, etc.