SCREENING TOOL

Please fill in all items as completely as you can. Use extra pages as necessary. If you do not have the information requested, please write “unknown.” If an item does not apply to your child, write “not applicable.” In order to be assured of prompt service, please return this form promptly to the Health Center for Children.

1. Chil’s Name :____ Date of Birth :_____________________________

   Address : ____

   Home Telephone Number : ___________________________Parent Work Telephone Number : _____________________

2. Full name and relationship of person filling out from :____

3. Is Child Adopted? ○ Yes ○ No Child’s age at adoption :____

   What information do you have regading the child’s family of origin? (biological family) Continue on back ____________

   If yes, what kind? ____

4. School currently attending :_____________________________ Grade ________________Special Class : ○ No ○ Yes

   If yes, what kind?____

5. List parents, brothers and sisters and others living in the home (Specify whether full, half, step, or foster)

First Name Last Name	Sex	Birthday Mo. Date Yr.	Age	School Grade or Occupation	Address (if different from above)	Relationship to child
Father :						❑ Full ❑ Step ❑ Foster
Mother :						❑ Full ❑ Step ❑ Foster
						❑ Full ❑ Half ❑ Not ❑ Step ❑ Foster ❑ Related
						❑ Full ❑ Half ❑ Not ❑ Step ❑ Foster ❑ Related
						❑ Full ❑ Half ❑ Not ❑ Step ❑ Foster ❑ Related
						❑ Full ❑ Half ❑ Not ❑ Step ❑ Foster ❑ Related
						❑ Full ❑ Half ❑ Not ❑ Step ❑ Foster ❑ Related

6. What are the concerns you have about your child ?____

____

CHILD’S HEALTH AND DEVELOPMENTAL HISTORY

7. Name and address of child’s of doctor ____

8. Who refered you to this facility ?____

9. What behaviors is your child exhibiting that are of concern to you?____

a. Which is the most troublesome?____

b. Was the mother ill during the pregnance? ❑ No ❑ Yes
If yes, describe the illness and any treatment, medication or special diet the mother received :__________________

c. Was alcohol, drugs or tobacco used during pregnancy? ❑ No ❑ Yes

d. Was your child born prematurely? ❑ No ❑ Yes ___________________________________ If yes, number of weeks?

e. How long did labor last ?____ f. Birth weight

f. How was the child born ? ❑ Head first ❑ Feet First ❑ Breech (buttocks first)
❑ Caesarean Section ❑ Other________ ❑ Not known

g. Were there any difficulties or pecularities in the Child's appearance or behavior at birth or during Infance?
❑ No ❑ Yes If yes, describe :____

h. Was the infant given oxygen : ❑ No ❑ Yes - for how long ? ____
Blood transfusion ? ❑ No ❑ Yes
Placed in an incubator? ❑ No ❑ Yes - for how long ? ____
Other medical treatment? ❑ No ❑ Yes - describe ____

i. At what age did your child first smile? __________________Walk alone ? _____________________________________
Say his/her first word? _______________________________**S**peak in sentences ?_______________________________

j. At what age was bowel training complete? ______________________ Urinary training? ________________________

Was there any difficully in training? ❑ No ❑ Yes - Describe ____

Any past 0r present problems in bowel or urinary control? ❑ No ❑ Yes - describe ____________________________

k. Has your child ever experienced serious illness, injury, or hospitalization, or has he/she any physical disabilities?
❑ No ❑ Yes - If yes, please describe and give age of child when problem occurred :__________________________
____

Has your child had :
Head injuries ? ❑ No ❑ Yes Describe :____

Seizures? ❑ No ❑ Yes Describe :____

Abnormal motor movements or twitches ? ❑ No ❑ Yes Describe :____

l. Is your child currently taking any medication? ❑ No ❑ Yes What medication :________________________________

Why was it prescribed :____

m. Has your child had difficulties in :

Eating ? ❑ No ❑ Yes - describe :____
Sleeping ? ❑ No ❑ Yes - describe :____
Speaking ? ❑ No ❑ Yes - describe :____
Menstruating? ❑ No ❑ Yes - describe :____

11. How long have these problems existed ?____

12. Has your child received treatment previously ? ❑ No ❑ Yes Where ?____

13. Have others expressed concern about your child (i.e. friends, school, police) ? ❑ No ❑ Yes
If yes, please describe : ____
____

SCREENING TOOL

CHECK IF YES TO ANY OF THE FOLLOWING CURRENT PROBLEMS

______ Problem paying attention
______ Acting without thinking
______ Unable to work quietly at home
______ Difficulty concentrating.
______ Difficulty finishing tasks.
______ Requires lots of supervision.
______ Often disobeys parent or teacher.
______ Often fidgets/always on the go.
______ Difficulty getting along with other children
______ Impulsive - acts without thinking
______ Gets into fights.
______ Problems with authority figures.
______ Lies frequently
______ Runs away.
______ Truant from school
______ Takes things that don't belong to hime/her.
______ Plays with matchs/sets fires.
______ Cruellty to animals
______ Cruelty to others
______ Fails to take responsibility for own behaviour.
______ Often loses temper.
______ Often argues with adults / authority figures.
______ Often does not follow rules.
______ Often actively defies or refuses adult requests.
______ Rebellious.
______ Swear/use obscence language.
______ Often blame others for his/her mistakes.
______ Loss of interest in activities.
______ Decreased energy
______ Significant weight loss/gain.
______ Cannot be cheered up.
______ Sleeping too litle/too much.
______ Down on self/worthless/guilty.
______ Unable to hae fun.
______ Withdrawal from parents.
______ Withdrawal from friends
______ Change from school performance.
______ Sensitive to rejection.
______ Complaints a lot about stomachaches/headaches.
______ Wishes he/she was not there.
______ " I wish I was dead." "Your'd be better off without me, if I was gone."
______ Any self destructive acts such as cutting of wrists.
______ Overdose.
______ Physically aggressive.
______ Verbally aggressive and threatening.
______ Destructive to property or objects.

____ Fearful of school

____ Fearful of the dark

____ Fearful of Strangers

____ Fearful of animals

____ Fearful of public speaking

____ Fearful of leaving home

____ Other fears________________

____ Generally worried

____ Worry about something happening to him/her

____ Afraid of being apart from you

____ Extremely shy

____ Worry about things before they Hapening to him/her

____ Perfectionist

____ Reccurring thoughts, acts, or images

____ Doing the same thing over

and over again

____ Hoarding

____ Checking over and over

____ Frequently washes hands

____ Excessive fear of germs

____ Alcohol or drug abuse

____ Any known or suspected physical or sexual abuse

____ Any sexual play or acting out-touching of self or others.

____ Nightmares

____ Difficulty in playing with others

____ Hearing voices (auditory hallucinations)'

____ Seeing objects/persons others do not see (Visual hallucinations)

14. Has anyone in your family had problems such as depression, anxiety, alcoholism, drug abuse, learing diffeculties or attention deficit disorder?

❑ No ❑ Yes

Relationship to patient :

Have they ever received treatment for this condition? ❑ No ❑ Yes

Are they currently being treated ? ❑ No ❑ Yes

Please explain and give names of any medications they are receiving :

____

____

____

____

____

____

14. Has anyone in your family had thyroid problems? ❑ No ❑ Yes

Relationship to patient :______________

Is there any other information you can think of that might pertai to your child's problems or might help us in understanding him/her better?

____

____

____

____

____

____

____

____

Parent Rating Scale

Child's ID : ______________________ **Gender : M F**
(Circle One)

Birthdate : ___/___/___ (**Month Day Year**) **Age :** _____ **School Grade :** ________

Parent's ID : ______________________ **Birthdate :** ___/___/___ (**Month Day Year**)

Instructions : Below are a number of common problems that children have. Please rate each item according to your child's behavior in the last month. For each item, ask yourself. " Ho w much of a problem has this been in the last month?", and circle the best answer for each one. If none, not at all, seldom, or very infrequently, you would circle 0. If very much true. or it occurs very often or frequently, you would circle 3. You would circle 1 or 2 for ratings in between. Please respond to each item.

	NOT TRUE AT ALL (NEVER, Seldom)	JUSTA LITTLE TRUE (Occasionally)	PRETTY MUCHTRUE (Often, Quite a Bit)	VERY MUCH TRUE (Very Often, Very Frequent)
1. Inattentive, easily distracted	0	1	2	3
2. Angry and resentful	0	1	2	3
3. Difficulty doing or completing homework...	0	1	2	3
4. Is always "on the go" or acts as if driven by a motor	0	1	2	3
5. Short attention span	0	1	2	3
6. Argues with adults	0	1	2	3
7. Fidgets with hands or feet or squirms in seat	0	1	2	3
8. Fails to complete assignments	0	1	2	3
9. Hard to control in malls or while grocery shopping	0	1	2	3
10. Messy or disorganized at home or school	0	1	2	3
11. Loses temper	0	1	2	3
12. Needs close supervision to get through assignments	0	1	2	3
13. Only attends if it is something he/she is very interested in	0	1	2	3
14. Runs about or climbs excessively in situations where it is inappropriate.	0	1	2	3
15. Distractibility or attention span a problem	0	1	2	3
16. Irritable	0	1	2	3
17. Avoids, expresses reluctance about, or has difficulties engaging in tasks that require sustained mental effort (such as schoolwork or homework)...	0	1	2	3
18. Restless in the "squirmy" sense...	0	1	2	3
19. Gets distracted when given instructions to do something	0	1	2	3
20. Actively defies or refuses to comply with adults' requests	0	1	2	3
21. Has trouble concentrating in class	0	1	2	3
22. Has difficulty waiting in lines or awaiting turns in games or group situations	0	1	2	3
23. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
24. Deliberately does things that annoy other people	0	1	2	3
25. Does not follow through on instructions and fails to finish schoolwork, chores or duties in the workplace (not due to oppositional behavior or failure to understand instructions)	0	1	2	3
26. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
27. Easily frustrated in efforts	0	1	2	3