BEHAVIORAL HEALTH CAREGIVER QUESTIONNAIRE

By completing this form, you are providing important information that will allow us to focus on your primary concerns during today's visit and also archive past medical history for future visits. If you do not know the answer to any of the questions below, please note with "?". Thank you for taking the time to provide this information.

Background Information

Child's name: ______________________ Age: ________ Today's date: ____________

Name of person completing this form: ______________________ Relationship to child: ____________

Primary Concerns

Please list the concerns you have about this child, with highest concern listed first.

Concern 1:______________________________

Concern 2:______________________________

Concern 3:______________________________

Birth History

Where was this child born?

How much did this child weigh at birth? ________ pounds ________ ounces Length of pregnancy? ________ weeks

Did the mother use any substances or medications during the pregnancy? *(Check all that apply)*

☐ Beer / Wine ☐ Tobacco ☐ Vaping ☐ Alcohol ☐ Marijuana ☐ Methamphetamine (Crystal / Ice)

☐ Cocaine ☐ Other ____________ ☐ Any prescription medication ____________

Were there any problems during pregnancy? ☐ Yes ☐ No ☐ ? ☐ Specify: ____________

Were there any problems during labor / delivery? ☐ Yes ☐ No ☐ ? ☐ Specify: ____________

Was this child born by Caesarean / C-Section? ☐ Yes — planned ☐ Yes — emergency ☐ No ☐ ?

Did this child remain in the NICU for any problems after birth? ☐ Yes ☐ No ☐ ? ☐ Specify: ____________

Was this child:

- Sitting up by 8 months? ☐ Yes ☐ No ☐ ?
- Walking by 15 months? ☐ Yes ☐ No ☐ ?
- Using 2-word phrases by 2 years? ☐ Yes ☐ No ☐ ?
- Speaking so strangers could understand by 3 years? ☐ Yes ☐ No ☐ ?
- Staying dry during the day by 4 years? ☐ Yes ☐ No ☐ ?
- Reading simple words by 6 years? ☐ Yes ☐ No ☐ ?

Was this child adopted? ☐ Yes ☐ No ☐ ?

Is this child in foster care? ☐ Yes ☐ No ☐ ?

Health History

Any major health problems? ☐ Yes ☐ No ☐ ?

Any hospitalizations? ☐ Yes ☐ No ☐ ?

Any surgery? *(including sedated dental, ear tubes)* ☐ Yes ☐ No ☐ ?

Any head injury, loss of consciousness? ☐ Yes ☐ No ☐ ?

Any vision or hearing loss? ☐ Yes ☐ No ☐ ?

Any seizures? ☐ Yes ☐ No ☐ ?

Any heart-related problems? ☐ Yes ☐ No ☐ ?

Any serious or chronic illness or injury? *(including poisoning, ingestion)* ☐ Yes ☐ No ☐ ? Specify: ____________

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Strengths

What are strengths you see in this child? ______

What are your goals for this child? ______

Medications

Please list all medications this child currently takes (including vitamins / supplements):

______ ______
______ ______
______ ______

School Information *(if over 3 years of age)*

Current school: ______ Length of time at this school: ______ Current grade: ______

Has this child:

- Repeated a grade? ☐ Yes ☐ No ☐ ?
- Received special education services? ☐ IEP ☐ 504 Plan ☐ Yes ☐ No ☐ ?
- Received disciplinary action? *(detention/suspension/expulsion)* ☐ Yes ☐ No ☐ ?

Family Mental Health History

Have any of the child's biological relatives experienced:	*(Check one)*	If yes, how is the person related to this child?
ADHD / ADD *(attention problems)*	☐ Yes ☐ No ☐ ?	
Learning or reading disability	☐ Yes ☐ No ☐ ?	
Anxiety	☐ Yes ☐ No ☐ ?	
Depression	☐ Yes ☐ No ☐ ?	
Suicide	☐ Yes ☐ No ☐ ?	
Bipolar Disorder / Manic Depression	☐ Yes ☐ No ☐ ?	
Autism Spectrum Disorder	☐ Yes ☐ No ☐ ?	
Other developmental delays or genetic condition	☐ Yes ☐ No ☐ ?	
Schizophrenia / Psychosis	☐ Yes ☐ No ☐ ?	
Alcohol / Substance use problems	☐ Yes ☐ No ☐ ?	
Incarceration *(biological parent only)*	☐ Yes ☐ No ☐ ?	
Eating disorder	☐ Yes ☐ No ☐ ?	
Tics or Tourette syndrome	☐ Yes ☐ No ☐ ?	

Child Mental Health History

Has this child ever had a mental health diagnosis? ☐ Yes ☐ No ☐ ? Specify: ______

Who diagnosed this condition? ______ When? ______

Has this child ever taken medications for mental/behavioral/emotional concerns? ☐ Yes ☐ No ☐ ? Specify: ______

Has this child ever received mental health counseling? ☐ Yes ☐ No ☐ ? Specify: ______

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Cultural History

Does child hear more than one language at home? ☐ Yes ☐ No ☐ ? If yes, specify: ______________________

Has child experienced discrimination, racism, or other disadvantage? ☐ Yes ☐ No ☐ ?

Has child had housing or food insecurity? ☐ Yes ☐ No ☐ ?

Social History

Please list all people currently living in the household with this child:

Name	Relationship to Child	Age	Education (adults)	Employment (adults)

Are there any immediate family members who do not live with this child (biological mother/father or siblings)? ☐ Yes ☐ No

The child's biological parents are currently (please check one):

☐ married to each other ☐ divorced from each other ☐ never married to each other

☐ separated from each other ☐ deceased ☐ don't know/other: ______________________

Have there been any major changes or stresses in this child's life, especially in the last 6 months (e.g., marital problems, a move, change of school, birth of a brother/sister, death of a pet)? ☐ Yes ☐ No

If yes, please specify: ______________________

Has this child experienced or seen any traumatic events (e.g., domestic violence, physical or sexual abuse, other violence, bullying, natural disaster, separation from primary caregiver for more than 1 month) that you would like to discuss? ☐ Yes ☐ No

If yes, please specify: ______________________

Would you like to discuss these issues separate from child? ☐ Yes ☐ No

Are there any major changes or stresses expected in the near future? ☐ Yes ☐ No

If yes, please specify: ______________________

Has CPS ever been involved with your family? ☐ Yes ☐ No

If yes, please specify: ______________________

Comments: Is there anything else you want to share that is not already listed here?

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