THE FRONTLINE CHILD QUESTIONNAIRE

Patient's Name:_____ **Date of Evaluation:**_____

Name of person completing this form/Relationship to child:_____

How long have you known this child?_____ Date form is completed:_____

Your answers to the following questions will allow us to help you and your child more effectively. Please answer all of the questions. If you do not know the answer, write "Don't know." If the question does not apply to this child's situation, write "N/A". Circle any particularly descriptive words.

IDENTIFYING DATA: Child's Age:_____ Sex: _____ Race/Ethnic Group: _____

Grade in School: _____ School Name and Teacher(s): _____

Who is living at home, their ages, and how are they related to the patient?

If one of the biological parents does not live with the child, where does that parent live?

Referred by: _____

PRESENTING PROBLEM: What kind of problems/symptoms prompted this evaluation to be arranged?

When did these problems first become evident?

What kind of stressful things have been going on in the child's or the parents' lives over the past couple of months or years?

REVIEW OF SYMPTOMS:

Have there been any *problems* with, *fluctuation* of, or *change* in your child's **sleep** pattern recently or in the past? _____ If so, describe:

What time does the child go to bed?_____

Does the child sleep in his/her own bed?_____

How long does it take to fall asleep?_____

What time does the child wake up?_____

Is he/she harder to wake than the average child?_____ If so, describe:

How often does the child wake up during the night?_____

What wakes the child up?_____

Has the child had any weight or **appetite** problems in the past or more recently?_____
Describe:

Have there been any problems with or fluctuations of the child's **energy** level?_____
Describe:

Does he/she have frequent **crying** spells?_____ How often and since when?_____

What kinds of things does your child **enjoy** doing when he/she feels well?
Has he/she been doing these things lately?

Have there been any *problems with* or *change in* **grades** or ability to learn?_____
Describe:

How long has this been going on?

Circle ***frequent* school problems** your child has had *prior to age 7*:

fidgeting being a chatterbox listening to the teacher concentrating being "hyper"

forgetfulness feeling dumb losing assignments being disorganized misbehaving

Draw a box around the items above that continue to be a problem for your child.

Approximately what *percentage* of the time does your child seem to have the following **feelings or mood**? When did these mood problems start?:

Sad?_____

Apathetic, bored, blah, "don't give a hoot about anything"?_____

Nervous, worried, tense, frightened?_____

Irritable, short-tempered, argumentative, easily frustrated?_____

Has your child made statements suggesting that he/she feels hopeless, helpless, worthless or guilty? _____ ("Nobody loves me", etc.) Please describe:

Has your child ever talked or written about killing himself/herself (**suicide**)?_____
Please describe:

Has he/she tried to kill himself/herself?_____ How?

Does your child have problems with constipation, diarrhea, **stomach aches**?_____

Does your child complain of **headaches** or **pain** anywhere else?_____

Has your child had any **panic attacks**, when "out of the blue", he/she has felt scared to death or as if he/she is losing his/her mind?_____ How often?_____
Has this feeling been accompanied by any of the following? (Please circle.)

Shortness of breath Chest pain Heart racing Dizziness Sweating Nausea

Numbness Headache Discomfort around people Fear of leaving his/her home or "safety zone"?

Has your child been troubled by **nightmares** or **intrusive memories** of upsetting things *that have actually happened* in the past?_____

Briefly state the traumatic experience:

Does your child seem to **worry** more than the average kid his/her age? _____
If so, how long has your child been a worrier?

What kinds of things does your child worry about?

Has your child done any **quirky** or **repetitive** or **overly superstitious** things?_____
Circle *and* describe:

Worries about germs or dirt Obsessive cleaning Excessive hand-washing or bathing

Touching or tapping Plucking hair Making lists Needing things to be perfect or even

Counting objects for no reason Checking locks, alarms, the stove, etc. Other:_____

Saving useless items/being a packrat

Do any family members have any of the traits listed above?_____ Who?_____

Has your child shown any **worrisome eating behavior?** _____
Circle *and* describe:

Making himself/herself throw up Going without food for extended periods

Diet pills Laxatives Binge eating

Does your child worry excessively about being **separated** from you?_____
Please describe:

Does your child worry so much about his/her **appearance** that it interferes with school or social activities? _____ If so, what does he/she think is wrong with his/her appearance?:

Is your child abnormally **shy?** _____ Please describe:_____

Has your child ever had any of his/her **senses** play tricks on him/her? (Such as hearing a voice call the child's name, or a voice yelling at him/her, or telling him/her that he/she is bad, or to hurt him/herself or others, seeing things that other people in the room don't see, distorted images, strange tastes or smells or peculiar sensations in the body.)_____
Please describe:

Has your child had any **frightening thoughts**, or **unusual beliefs,** or ideas or behavior that seemed peculiar or out-of-touch with reality? (Such as thinking that the TV or radio announcer was talking directly to him/her, or that someone was out to do the child harm when that wasn't really the case, or that he/she had any special powers, or was cursed, etc.) _____
Please describe:

MOOD DISORDER QUESTIONNAIRE (MODIFIED FOR CHILDREN)

Hirschfield & Spitzer, et al Reprinted and modified with permission.

Has there *ever* been a period of time when your child was not his/her usual self and...	**YES**	**NO**
...felt so good or so hyper that other people thought your child was not his/her normal self or was so hyper that he/she got into trouble?		
...was so irritable that he/she shouted at people or started fights or arguments?		
...felt or appeared to feel much more self-confident than usual?		
...got much less sleep than usual and appeared as if he/she didn't really miss it?		
...was much more talkative or spoke much faster than usual?		
...thoughts raced through his/her head or your child couldn't slow his/her mind or conversation down?		
...was so easily distracted by things around him/her that he/she had trouble concentrating or staying on track?		
...had much more energy than usual?		
...was much more active or did many more things than usual?		
...was much more social or outgoing than usual, for example, telephoned friends in the middle of the night?		
...was much more interested in sex than usual for a child of his/her age?		
...did things that were unusual for him/her or that other people might have thought were excessive, foolish, or risky?		
...spending money or taking things not belonging to the child got him/her or your family into trouble?		
If you checked YES to more than one of the above, have several of these ever happened at the same time?		
How much of a problem did any of these cause – like being unable to work or attend school; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* No problem Minor problem Moderate problem Serious problem		
Have any of your child's blood relatives (i.e. siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?		
Has a health professional ever told you that your child has manic-depressive illness or bipolar disorder?		
Does your child's mood ever change so suddenly that it's like somebody "flipped a switch"? (This question is a Shrinklady addition.)		
Is it possible to predict what your child's behavior will be like from one hour to the next? (This question is a Shrinklady addition.)		

Please describe any "YES" answers:

If **racing thoughts** have been present, please circle the words that best describe the nature of those racing thoughts:

Worries circling in the mind like a hamster on a wheel Jumbled Confused

No logical connecting thread between thoughts Noisy mind that won't shut off

PSYCHIATRIC HISTORY:

Has your child ever been **hospitalized** for psychiatric or substance abuse problems?_____

How many times?_____

Where? When? Name of Doctor?

Has your child taken any **medications** to treat any psychiatric disorders?_____

Please list:

Name of Medication Dr. who prescribed Approx. treatment dates Response and/or side effects

Has your child had any **counseling** or talk therapy?_____

Who was the counselor?

Approximate dates:

What issues were addressed?

Was it helpful?

Has your child ever attempted **suicide**?_____ How many times?_____

How old was he/she? What was going on at the time?

Has your child ever **deliberately inflicted pain** upon himself/herself?_____

How, when and what purpose did it serve?

Has your child ever threatened to kill anyone or deliberately inflicted pain on animals or other people?___
Please describe:

Has your child been preoccupied with **fire** or **weapons**?_____ Please describe:

PAST MEDICAL HISTORY:
Were there any complications to biological mother's **pregnancy** with or **delivery** of this child?_____
Please describe:

Vaginal or C-section delivery?

Was the developing baby exposed to drugs or alcohol?_____

Did this child reach **developmental milestones** (sitting up, rolling over, walking, talking, etc.) within the usual time frame?_____ If not, please describe problems in development:

As a baby, was the child *"colicky", fussy", "average", or "easy"?*
Please describe:

Who and where is this child's **pediatrician** or **family physician**?

Please list and describe any significant **health problems** or surgeries the child has had:

For adolescent girls, have **menstrual** periods started?_____

At what age?_____

Is she more irritable, anxious or depressed in the week prior to her period?_____

Circle any of the following health problems your child has had:
(Mark an "X" through those that do not apply.)

High blood pressure Heart disease Lung disease Asthma/allergies Cancer

Blood sugar too high or too low Head injury Glaucoma Sexually transmitted disease

Seizures Kidney disease Liver disease Thyroid disease Unintended pregnancy

Please list all of the **prescription** and **non-prescription** medications, **supplements** and **herbal remedies** your child has taken over the past few months:

Current: Took recently, but has stopped taking: Name of prescribing doctor:

Has your child had problems with **bedwetting** beyond the age of 4 or 5?_____

How often?

Have blood relatives on either side of the child's family wet the bed into teen-age years?_____

Is your child **allergic to any medications?**_____ Please list:

FAMILY HISTORY:

Please list any significant medical illnesses among blood relatives. Who had what illness?

Specifically, any thyroid disease or sleep disorders?

Please list any **psychiatric illness** you feel may have existed among blood relatives, whether evaluated and treated or not. (Anxiety, panic attacks, obsessive-compulsive disorder, depression, mood swings, erratic behavior, manic-depression, bipolar disorder, schizophrenia, ADHD, eating disorders, etc.)

Who had what illness?

Have any blood relatives struggled with drug or alcohol problems? Who had what problems?

SOCIAL HISTORY:

Were this child's biological parents married?_____

Divorced?_____

Who has custody?_____

Visitation schedule with non-custodial parent?_____

Who pays child support?_____

Please list this child's siblings, where they live, how often your child sees them, how they get along:

Has DFS or foster care been involved with this child's family?_____ Why?

Please describe any learning or disciplinary problems this child has had, or is having in school:

Is there an IEP or 504 Plan at school for this child?_____

Has this child worked outside of the home?_____ Doing what?

Have any disability claims ever been filed on this child?_____ What kind?

Please list any juvenile justice or other legal problems your child has had:
Who is the juvenile officer?

Have there been, or do you suspect that this child has drug or alcohol abuse problems?
Please describe:

Please circle any of the following that this child has experienced:
Please describe when and who was involved:

Physical abuse Emotional abuse Sexual abuse Witness of violence

How many and what kind of caffeinated beverages does this child drink each day?

Does this child smoke?_____ How much?_____ When did he/she start?_____
Where does the cigarette money come from?

THANK YOU FOR YOUR TIME AND PATIENCE IN COMPLETING THIS QUESTIONNAIRE.
Please present it to the receptionist for the doctor to review prior to your appointment.

For clinic use only below this line:
MSE:

DIAGNOSTIC IMPRESSION:

Axis I: Primary and comorbid psychiatric or substance abuse problems

Axis II: Learning disabilities, personality features, IQ issues

Axis III: General medical problems

Axis IV: Stresses in the child's and/or family's lives

Axis V: Global Assessment of Functioning (Place an "X" where appropriate)

100	90	80	70	60	50	40	30	20	10	0
Exceptional functioning	*Good functioning*	*Transient stress-related symptoms*	*Mild symptoms OK overall functioning*	*Moderate symptoms in one area*	*Serious problems in several areas*	*Major impairment in several areas*	*Inability to function in almost all areas*	*Some danger to self or others*	*Persistent danger to self or others*	*Insuff info to assess*

TREATMENT PLAN:

1. **Labs:** (Circle labs ordered and write in any additional testing.)

   CBC with diff, comprehensive metabolic panel, lead level, lipid panel, TSH, UA, urine drug screen

2. Have patient and family read "Helping Yourself Feel Better" for information on managing stress.
3. Suggest appropriate books/websites for patient and family to read.
4. Instruction regarding alcohol, caffeine, diet, relaxation training.
5. Psychotherapy referral. (Where appropriate.) Name of therapist/agency:_____
6. Multivitamin with extra B complex daily for all, folic acid & calcium for girls.
7. **Psychotropic medication(s):** (Including printed instructions and "Regarding Medication" sheet.)
   ☐ Informed consent discussion held ☐ Off-label use discussion held

8. **Return visit** in _____ weeks.

Patient Name:_____ DOB:_____ Date of Evaluation:_____