Quality Life

Confidential Family Questionnaire – Adolescent Packet

I GENERAL INFORMATION

Child's Name: _____ Sex: ___ Identified Gender: _____ Age ___ Date of Birth: _____

Address: _____

Phone: _____

Parent 1 - Name:

_____

If not natural parent, give relationship:_____

Address (if different from above) _____

Parent 2 - Name: _____

If not natural parent, give relationship:_____

Address (if different from above) _____

If not presently with the child, please give whereabouts of biological father and mother:

Father:_____ Mother:_____

Parents are: _____ Married _____Divorced

_____Separated _____Living together

Legal custodian of child, if other than natural parent(s): _____

Referring person or agency:_____

Address:_____

Name(s) of person(s) completing this form:_____

Relationship to child:_____

II CHILD'S CURRENT PROBLEMS AND THEIR HISTORY:

1. Describe the child's current problem(s) (medical, behavioral, emotional)
    a. _____
    b. _____
    c. _____
    d. _____

2. When did the current problem(s) start or when did you first notice them? _____

_____

_____

_____ 1.

What do you think is the cause of the current problem(s) ? _____

_____

_____

2. Describe your child's strengths and weakness

STRENGTHS:

___ athletic ___ physical health ___ sense of humor

___ sociable ___ social support ___ housing situation

___ intelligent ___ family support ___ problem solving skills

___ caring ___ follow rules ___ school/work functioning

___ confident ___ communicate well

Comments:

WEAKNESSES:

___ shy ___ argumentative ___ social support

___ angry ___ frightens easily ___ family support

___ impulsive ___ physical health ___ problem solving skills

___ impatient ___ cognitive/intellect ___ work functioning

___ housing situation

Comments:

III CHILD'S EDUCATION

1. School your child is presently attending: _____
   Locations: _____ Grade Completed_____
2. Other school attended by your child and approximate date of attendance:

   _____

   _____
3. Child's academic strengths: _____

   _____
4. Child's academic weaknesses or problems: _____

   _____

5. Child's behavior problems in school: _____

_____

6. Please check what you feel best describes your child in the following areas:

	Above Average	Average	Below Average
Grades:	_____	_____	_____
Ability:	_____	_____	_____

Attendance: _____ Usually Present
_____ Often absent with excuse
_____ Truant

Relations with peers: _____ Excellent
_____ Usually gets along
_____ Problems

Relations with teachers: _____ Excellent
_____ Usually gets along
_____ Problems

IV CHILD'S DEVELOPMENT

A. Pregnancy (Place a question mark (?) on the "yes" line if you do not know)

	Yes	No
1. Was this pregnancy:		
Planned?	_____	_____
Desired by mother?	_____	_____
Desired by father?	_____	_____
Of normal duration? If no, give Duration _____ months	_____	_____

2. Check problems during pregnancy:

	Yes	No
High blood pressure	_____	_____
Low blood pressure	_____	_____
Sugar in the urine	_____	_____
Protein in the urine	_____	_____
Bleeding or spotting	_____	_____
High fever	_____	_____
Cold blisters on lips	_____	_____
German (3 day) measles	_____	_____
Rh problems	_____	_____
Other problems (specify)	_____	_____

	Yes	No
3. During the course of the pregnancy:		

Did you take any medications? _____ _____
If yes, what kind/how long?
_____
Did you smoke cigarettes? _____ _____
If yes, how many/day? _____
Did you drink alcohol? If _____ _____
yes, give details _____
_____
Were you dependent on or
Taking drugs? _____ _____
If yes, give details _____
_____
Did you have x-rays? If yes, when _____ _____ During
pregnancy and how many?
_____

4. What month in your pregnancy did you start seeing the doctor regularly?
_____

B. Delivery (Place a question mark (?) on the "yes" line if you do not know)

	Yes	No
1. Was labor unusually long:	____	_____
If yes, how many hours? _____		
2. Was delivery aided by forceps Or vacuum?	____	_____
3. Was your child born by C-section?	____	_____
4. Was more than one baby born?	____	_____
5. Was child blue at birth?	____	_____
6. Was child yellow (jaundiced) During first week?	____	_____
7. Was child administered oxygen At birth?	____	
_____		
8. Was child placed in an incubator?	____	
_____ 9. Was anything other than above Wrong with the baby? If yes	____	_____
Give details: _____		
10. Did the mother have any problems During or immediately after delivery?	____	_____
If yes, give details: _____		
11. What was child's weight at birth?	_____	

12. What was child's length at birth? _____

13. How long did you stay in the hospital? _____

14. How long did your baby stay in the hospital? _____

C. Early development (Place question mark (?) in the "yes" line if you do not know)

1. How old was your child when he/she:

a. Established eye contact with someone _____

b. Said first words _____

c. Said first sentence _____

d. Was bladder trained during the day _____

e. Was bladder trained during the night _____

f. Was bowel trained _____

2. Has your child sought any sexual information from parents? ___ Y ___ N

If yes, describe nature of questions and how you handled them: _____

_____

_____

3. Has your child started developing sexual characteristics? ___ Y ___ N

If yes, age of onset: _____

For girls: date of first menstrual period: _____

Cramps or other physical discomfort? ___ Y ___ N

If yes, please describe: _____

_____

What was her attitude toward menstruation? _____

4. Has onset of puberty appeared to cause any difficulties for your child?

___ Y ___ N

If yes, give details: _____

_____

5. Has your child ever behaved or talked in a way that was not appropriate for a girl/boy of her/his age? ☐ Y ☐ N

If yes, give details: _____

_____

_____

Nature of behavior: _____

Age of child at the time: _____ Who noticed the behavior? _____

What was done about it? _____

D 1. Regarding the child's interactions with others:

	YES	NO	IS IT A PROBLEM?

Is the child usually a loner?			
Does the child prefer younger children?			
Does the child prefer older children?			
Does the child prefer adults?			
Does the child usually avoid situations in which he/she would be a follower?			
Does the child usually avoid situations in which he/she would be a leader?			
Does the child have frequent fights with adults?			
Does the child have frequent fights with peers?			
Does the child have frequent fights with siblings?			

IF YOUR Child HAD 3 WISHES ABOUT ANY CHANGES IN YOURSELF, SCHOOL, WORK, FAMILY, WHAT WOULD THEY BE:

1.

2.

3.

Psychiatric History

1

Psychiatric Hospitalizations

Where	Dates	Reason

Outpatient Services/Therapy

Where and with whom?	Dates	Reason	Did you find this helpful?

Neuropsych/Psychological Testing

Where	Tests Performed	Outcome/Diagnosis

MEDICATION HISTORY Please list all medications taken currently as well as previously. Commonly prescribed medications are listed below.

Medication & Dose_____ _____ Currently ___ Previously ___

Medication & Dose_____ _____ Currently ___ Previously ___

Medication & Dose_____ _____ Currently ___ Previously ___

Medication & Dose_____ _____ Currently ___ Previously ___

Medication & Dose_____ _____ Currently ___ Previously ___

Medication & Dose_____ _____ Currently ___ Previously ___

Medication & Dose_____ _____ Currently ___ Previously ___

Antidepressants

Amitriptyline/Elavil
Bupropion/Wellbutrin
Citalopram/Celexa
Desipramine/Norpramin
Desvelafaxine/Pristiq
Duloxetine/Cymbalta
Escitalopram/Lexapro
Fluoxetine/Prozac
Fluvoxamine/Luvox
Levomilnacipran/Fetzima
Imipramine/Norpramin
Mirtazapine/Remeron
Nortriptyline/Pamelor
Paroxetine/Paxil
Sertraline/Zoloft
Trazodone/Desyrel
Venlafaxine/Effexor
Vilazodone/Viibryd
Vortioxetine/Trintellix

Atypical/Mood Stabilizers

Ariprazole/Abilify
Asenapine/Saphris
Brexpiprazole/Rexulti
Clozapine/Clozaril
Haloperdol/Haldol
Lurasidone/Latuda
Olanzapine/Zyprexa
Paliperidone/Invega
Quetiapine/Seroquel
Risperdone/Risperdal
Ziprasidone/Geodon

Anti-epileptic/Mood Stabilizers

Carbamazepine/Tegretol
Gabapentin/Neurontin
Lamotrigine/Lamictal
Levetiracetam/Keppra
Oxcarbazepine/Trileptal
Topiramate/Topomax
Valproate/Depakote
Lithium

Anti-Anxiety Medications

Alprazolam/Xanax
Buspirone/Buspar
Clonazepam/Klonopin
Diazepam/Valium
Hydroxyzine/Vistaril
Lorazepam/Ativan

Sleep Aids

Eszopiclone/Lunesta
Ramelteon/Rozarem

The Child Bipolar Questionnaire - Version 2.0

Please complete the following survey. All fields are required except where noted.

Instructions:

My child has and/or had the following symptoms and/or behaviors. You may have noticed a behavior as far back as early childhood or you may have observed it more recently. In either case, estimate how frequently the behavior has occurred since you first noticed it. In other words, please rate these symptoms and/or behaviors as they were at their most severe and/or prior to your child starting medication. Then select a number in the "Frequency" column using the following key, to represent the frequency of occurrence:

Never or hardly ever	Sometimes	Often	Very often or almost constantly
1	2	3	4

Child's first name:

Child's date of birth: mm/dd/yyyy

Child's Gender: Male Female

Symptom/Behavior	**Frequency**			
	1	**2**	**3**	**4**
1) displays excessive distress when separated from family				
2) exhibits excessive anxiety or worry				
3) has difficulty arising in the AM				
4) is hyperactive and easily excited in the PM				
5) has difficulty settling at night				
6) has difficulty getting to sleep				
7) sleeps fitfully and/or awakens in the middle of the night				
8) has night terrors and/or nightmares				
9) wets bed				
10) craves sweet-tasting foods				
11) is easily distracted by extraneous stimuli				
12) is easily distracted during repetitive chores & lessons				
13) demonstrates inability to concentrate at cshool				

14) attempts to avoid homework assignments				
15) able to focus intently on subjects of interest and yet at times is easily distractible				
16) has poor handwriting				
17) has difficulty organizing tasks				
18) has dfficulty making transitions				
19) has difficulty estimating time				
20) has auditory processing or short-term memory deficit				
21) is extremely sensitive to textures of clothes, labels, and tightness of fit of socks or shoes				
22) exhibits extreme sensitivity to sound and noise				
23) complains of body temperature extremes or feeling hot despite neutral ambient temperature				
24) is easily excitable				
25) has periods of high, frenetic energy and motor activation				
26) has many ideas at once				
27) interrupts or intrudes on others				
28) has periods of excessive and rapid speech				
29) has exaggerated ideas about self or abilities				
30) tells tall tales; embellishes or exaggerates				
31) displays abrupt, rapid mood swings				
32) has irritable mood states				
33) has elated or silly, goofy, giddy mood states				
34) displays precocious sexual curiousty				
35) exhibits inappropriate sexual behaviors, e.g. openly touches self or others' private parts				
36) takes excessive risks				
37) complains of being bored				
38) has periods of low energy and/or withdraws or isolates self				

39) has decreased initiative				
40) experiences periods of self doubt and poor self-esteem				
41) feels easily criticized and/or rejected				
42) feels easily humiliated or shamed				
43) fidgets with hands or feet				
44) is intolerant of delays				
45) relentlessly pursues own needs and is demanding of others				
46) is willful and refuses to be subordinated by others				
47) argues with adults				
48) is bossy towards others				
49) defies or refuses to comply with rules				
50) blames others for his/her mistakes				
51) is easily angered in response to limit setting				
52) lies to avoid consequences of his/her actions				
53) has protracted, explosive temper tantrums				
54) has difficulty maintaining friendships				
55) displays aggressive behavior towards others				
56) has destroyed property intentionally				
57) curses viciously, uses foul language in anger				
58) makes moderate threats to others or self				
59) makes clear threats of violence to others or self				
60) has made clear threats of suicide				
61) is fascinated with gore, blood, or violent imagery				
62) has acknowledged experiencing auditory and/or visual hallucinations				
63) hoards or avidly seeks to collect objects or food				
64) has concern with dirt, germs, or contamination				
65) is very intuitive and/or very creative				

Quality Life H & P

Name _____ SS# _____ Date_____

Drug Allergies:	**Family History:**	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
	Heart Disease						
	High Blood Pressure						
	Stroke						
	Cancer						
	Glaucoma						
Current Medications:	Diabetes						
	Epilepsy/Convulsions						
	Bleeding Disorder						
	Kidney Disease						
	Thyroid Disease						
	Mental Illness						
	Osteoporosis						

Hospitalizations or Surgery

Reason	**Date**	**Reason**	**Date**

Medical History

____ Headaches
____ Shortness of Breath
____ Heart Palpitations
____ Heart Murmur
____ Chest Pain
____ Dizziness/Fainting
____ Peripheral Vascular Disease
____ Allergies/Hay Fever
____ Asthma
____ Bronchitis
____ Pneumonia
____ Ulcer
____ GI Disorder

____ Lactose Intolerance
____ Gallbladder Disease
____ Prostate Disease
____ Bowel Irregularity
____ Incontinence
____ Sexual/Menstrual dysfunction
____ Venereal Disease
____ Frequent Infections
____ Hepatitis
____ Anemia
____ Arthritis
____ Osteoporosis
____ Nervousness

____ Depression
____ Gout
____ Scarlet Fever
____ Chronic Rashes
____ Rheumatic Fever
____ Mumps
____ Measles
____ Rubella
____ Polio
____ Diptheria
____ Tetanus
____ Other
____ Other

<u>Women Only</u>

Pregnant? Yes No Planning Pregnancy? Yes No

Men Only

It's common for men to occasionally experience erection difficulties. Is this something that happens to you? ___ Yes ___ No

How often does this occur? ___ Frequently ___ Sometimes ___ Rarely

Habits:

_ Smoke: Packs daily _____
How long? _____
Interested in stopping? _____

_ Coffee Cups daily _____
Other caffeine _____

_ Alcohol Type _____
Amount _____

___ Diet Salt Intake _____
Fat Intake _____

__ Sleep: Difficulty falling asleep _____
Continuity disturbances _____
Snoring_____
Early Morning Awakening _____
Daytime drowsiness _____

_____ Other_____

NICHQ Vanderbilt ASSESSMENT Scale –TEACHER Informant - GIVE FORM TO YOUR CHILD'S TEACHER

Teacher's Name:_____ Class Time: _____ Class Name/Period:_____ Today's Date: _____ Child's Name: _____ Grade Level: _____ **Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.**

Is this evaluation based on a time when the child ⑧ was on medication ⑧ was not on medication ⑧ not sure?

SYMPTOMS	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork.	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities.	0	1	2	3
3. Does not seem to listen when spoken to directly.	0	1	2	3
4. Does not follow through on instructions and fails to finish school work (not due to oppositional behavior or failure to understand).	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort.	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books).	0	1	2	3
8. Is easily distracted by extraneous stimuli.	0	1	2	3
9. Is forgetful in daily activities.	0	1	2	3

Total number of questions scored "2" or "3" in question #'s 1-9:_____

10. Fidgets with hands or feet or squirms in seat.	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected.	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected.	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly.	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor."	0	1	2	3
15. Talks excessively.	0	1	2	3
16. Blurts out answers before questions have been completed.	0	1	2	3
17. Has difficulty waiting in line.	0	1	2	3
18. Interrupts or intrudes on others (e.g., butts into conversations/ games).	0	1	2	3

Total number of questions scored "2" or "3" in question #'s 10-18:_____

Total Symptom Score for question #'s 1-18:_____

19. Loses temper.	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules.	0	1	2	3
21. Is angry or resentful.	0	1	2	3
22. Is spiteful and vindictive.	0	1	2	3
23. Bullies, threatens, or intimidates others.	0	1	2	3
24. Initiates physical fights.	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (e.g., "cons" others)	0	1	2	3
26. Is physically cruel to people.	0	1	2	3
27. Has stolen items of nontrivial value.	0	1	2	3
28. Deliberately destroys others' property.	0	1	2	3

Total number of questions scored "2" or "3" in question #'s 19-28:_____

	Never	Occasionally	Often	Very Often
29. Is fearful, anxious, or worried.	0	1	2	3
30. Is self-conscious or easily embarrassed.	0	1	2	3
31. Is afraid to try new things for fear of making mistakes.	0	1	2	3
32. Feels worthless or inferior.	0	1	2	3
33. Blames self for problems; feels guilty.	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him/h r." e 3		0	1	2
35. Is sad, unhappy, or depressed.	0	1	2	3

Total number of questions scored "2" or "3" in question #'s 29-35:_____

PERFORMANCE ***Academic Performance***	**Excellent**	**Above Average**	**Average**	**Somewhat of A Problem**	**Problematic**
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written Expression	1	2	3	4	5
Classroom Behavioral Performance	**Excellent**	**Above Average**	**Average**	**Somewhat of A Problem**	**Problematic**
39. Relationship with peers	1	2	3	4	5

40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Total number of questions scored "4" or "5" in question #'s 3643:_____

Average Performance Score:_____

COMMENTS:

PLEASE RETURN THIS FORM TO : Quality Life
MAILING ADDRESS : 1316 23rd Street South
Fargo, ND 58103

FAX NUMBER : 701-478-0434 **PHONE: 701-478-0333**

NICHQ

INTAKE INFORMATION – ADOLESCENT TO COMPLETE

DATE: **NAME:** **OCCUPATION:**

LIVING SITUATION: **HOBBIES:**

PERSONAL STRESS: {1 – 10 worst] **WORK STRESS: [1 – 10 worst]**

STRESS REDUCTION/RELAXATION:

RELIGION/SPIRITUALITY: ***Do you (the patient) consider yourself spiritual or religious? Do you belong to a spiritual community?***

___ increase/decrease in spiritual interest
___ change in expectations for your health
___ use prayer in your life
___ a feeling that life is meaningless or empty
___ participate in religious/spiritual practices
___ loss of family member, friend or significant other
___ change in your relationship w/ God or deity
___ increased fear, anger or bitterness
___ feeling of lingering sadness

MEDITATION PRACTICE:

SLEEPING HABITS:

EXERCISE HABITS:

EATING HABITS:

~~ALCOHOL/DRUG USE:~~ ~~CAGEAID~~

Have you ever:

☐ felt you ought to cut down n your drinking or drug use?
☐ had people annoy you by criticizing your drinking or drug use?
☐ felt bad or guilty about your drinking or drug use?
☐ had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover or to get the day started?

CURRENT HEALTH CARE PROVIDERS:

CURRENT MEDICATIONS:

SIGNIFICANT PAST MEDICAL HISTORY:

SEXUALITY:

Are you sexually active? Y N If so, do you practice safe sex? Y N
What method of contraception do you use? Birth Control Pill Diaphragm Condom Other: Have you had or do you have a venereal disease? Y N If yes:
Sexual Orientation: Heterosexual ("straight")____ Homosexual ("gay")____ Bisexual ____ Transgender____
Preferred Pronoun____

STRENGTHS:

☐athletic ☐ physical health ☐ sense of humor
☐sociable ☐ social support ☐ housing situation
☐intelligent ☐ family support ☐ problem solving skills
☐caring ☐ follow rules ☐ school/work functioning
☐ confident ☐ communicate well **Comments:**

WEAKNESSES:

☐ shy ☐ argumentative ☐ social support
☐ angry ☐ frightens easily ☐ family support
☐ impulsive ☐ physical health ☐ problem solving skills
☐ impatient ☐ cognitive/intellect ☐ work functioning
☐ housing situation
Comments:

REASON FOR APPOINTMENT:

IF YOU HAD 3 WISHES ABOUT ANY CHANGES IN YOURSELF, SCHOOL, WORK, FAMILY, WHAT WOULD THEY BE:

1.
2.
3.

Quality Life
1316 23rd Street South
Fargo, ND 58103

Mood Disorder Questionnaire Adolescent Version (MDQ-A)

Patient Name: _____Date of Birth: _____ Completed by: _____ Date: _____

I. Has there ever been a time for a week or more when your adolescent was not him/her usual self and…

	Yes	No
1. Felt too good or excited?	□	□
2. Was so irritable that he/she started fights or arguments with people?	□	□
3. Felt he/she could do anything?	□	□
4. Needed much less sleep?	□	□
5. Couldn't slow down his/her mind or racing thoughts?	□	□
6. Was so easily distracted by things?	□	□
7. Had much more energy than usual?	□	□
8. Was much more active or did more things than usual?	□	□
9. Had many boyfriends or girlfriends at the same time?	□	□
10. Was more interested in sex than usual?	□	□
11. Did many things that were foolish or risky?	□	□
12. Spent too much money?	□	□
13. Used more alcohol or drugs?	□	□

II. If you checked YES to more than one of the above, has several of these happened to your adolescent during the same period of time? **YES** **NO**

III. How much problems did any of this cause your adolescent- like school problems, failing grades, problems with family and friends, legal trouble…? Please circle one response only.

No problem **Minor problem** **Moderate problem** **Serious problem**

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

Office use only: **Severity score:** _____

Quality Life

GAD-7

Name: _____ Date: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Add columns _____ + _____ + _____

Total: _____

8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all Somewhat difficult Very difficult Extremely difficult	_____ _____ _____ _____