PARENT DIAGNOSTIC QUESTIONNAIRE

Your child has been referred to the DRKC to complete an evaluation that will help the court decide the best placement for him or her. To help the treatment staff create the most accurate evaluation possible, we ask parents/caregivers to answer the following questions. Answering these questions fully and honestly will help the treatment staff develop recommendations suited to your child's specific needs.

Resident_____ Date: _____
Date of Birth:_____ Place of Birth:_____
Name/Relationship to resident:_____

CURRENT BEHAVIORAL CONCERNS

What problems do you think your child has that helped to cause her/him to get into trouble?

_____

When did these problems first begin?

_____

How have your attempted to deal with these problems? (Discipline, Evaluations, Treatment, etc.)

_____

Do you feel that the family can cope with these problems when she/he returns home? And how so?

_____

Do you feel your child has been treated fairly during these legal processes?

_____

DEVELOPMENTAL HISTORY

Was your child: ☐ Premature (Length of pregnancy in weeks: ____) ☐ Full-Term
Were there any health problems in the pregnancy? (Diabetes, high blood pressure, excessive stress, other medical concerns.) ☐ Yes ☐ No

Please describe: _____
List vitamins and other medications taken during pregnancy:

_____

Were there any problems during labor and delivery?
(Induced pregnancy, C-section, umbilical cord, breathing problems, etc) ☐ Yes ☐ No

Please describe. _____
Did your child have any health problems as a newborn or infant? ☐ Yes ☐ No

Please describe. _____
Did you breastfeed? ☐ Yes ☐ No
Did the mother smoke cigarettes or use other forms of tobacco while pregnant? ☐ Yes ☐ No
Did the mother drink any alcohol while pregnant? ☐ Yes ☐ No
How often and how much alcohol was consumed weekly? _____
Did the mother use any other substances, including marijuana, while pregnant? ☐ Yes ☐ No

How much did she use each day? _____
Was the child's mother given any prescription medications while pregnant? ☐ Yes ☐ No

Which ones? _____
Do you feel he/she did the following on time, early or late?

Walk: _____
Talk: _____
Potty-Train: _____

Did your child: Wet the bed? ☐ Yes ☐ No What age did this stop?: _____

Did they have problems sleeping through the night? ☐ Yes ☐ No
At what age did they stop taking naps? _____
Do they still have difficulty sleeping? ☐ Yes ☐ No
What is the longest number of days in a row they have been unable to sleep or gotten 2-3 hours of sleep without intentionally trying to stay awake? _____

What kind of temperament did they have as an infant or toddler?
Easy vs. Hard to soothe when upset Easy vs Hard to warm up to others and new situations

Did they cry a lot, colicky? ☐ Yes ☐ No
Did you ever determine why? _____
Were they affectionate? ☐ Yes ☐ No
At what age did any of this change if it ever did? _____

How do they react when they are disciplined or told no? _____
Are their tantrums severe? ☐ Yes ☐ No
What age did the tantrums begin? _____ Have they stopped? ☐ Yes ☐ No

Are the tantrums more verbal, physical or both? _____

How frequent is the verbal aggression/outbursts? _____ times (daily/weekly/monthly)
How frequent is the physical aggression (toward people or objects)? _____ times (daily/weekly/monthly)

BEHAVIORAL
Identify any of the following that describe your child:

Frequent Headaches	Shaky Hands	Lonely
Dizziness/Fainting Spells	Doesn't seem to ever have fun	Can't Concentrate/Confused
Racing Heart	Can be spiteful and vindictive	Intentionally disobeys
Stomach or Bowel Problems	Seems Depressed	Feels Worthless
Seems resentful	Can't Relax	Feels Guilty
Appetite Changes	Sexual Problems	Can't Do Anything Right
Intense Anger	Deliberately annoys others	Aggressive/Fighting
Frequent Nightmares	Shy	Feels Ugly
Panicky/Tense/Anxious	Memory Problems	Misunderstood

At what age/school year did you notice a change or increase in negative behavior? _____

Please check:	**YES**	**NO**
Does your child tend to blame others for his/her mistakes?		
Is your child concerned about his/her own behaviors?		
Do they express no control over their own behavior?		
Do they seem to feel guilty when they do something wrong? Do they act without considering the consequences?		
Do they lie easily and skillfully?		
Do they keep their word?		
Do they brag about their things and their accomplishments?		
Can they easily con others into giving them or doing what they want?		
Are they concerned about others' feelings?		
Do they seem to have difficulty showing emotion?		
Has your child exhibited violence toward animals or younger siblings?		
Has your child set fires?		
Does your child sneak out at night?		
Does your child stay gone for extended periods without checking in, including overnight?		
Would you say your child is touchy or irritable almost every day?		
Does your child occasionally been *excessively* irritable or enraged for a distinct period of four days to a week that is very different from their normal personality?		
How about excessively happy or full of themselves?		
Have you ever noticed your child having an interest or fascination with guns?		
Violence?		

When did this interest begin? _____ Has it intensified? _____

Has your child ever participated in any self-injurious behaviors such as cutting, or intentional scarring? ☐ Yes ☐ No
When did this begin? How frequent does it occur? Have you noticed anything that causes them to do it?

_____

Has your child ever threatened or attempted suicide? ☐ Yes ☐ No
How many times? How did they attempt it? Was there lethal intent?

_____

Has your child ever seen a doctor/counselor for problems with his/her mood or nerves? ☐ Yes ☐ No

Where and dates. _____

Did she/he receive medications? ☐ Yes ☐ No
Dates: _____ Medication: _____

Compliance and effectiveness: _____

Has your child ever needed medical treatment after attempting to hurt herself/himself? ☐ Yes ☐ No
Has your child ever been placed in a psychiatric hospital because she/he wanted to hurt or kill herself/himself?
☐ Yes ☐ No
Has your child spent time in a psychiatric facility for other reasons? _____

Hospital Names and dates of stay:_____

Have any of your child's friends or family members hurt or killed themselves? ☐ Yes ☐ No
Who/what happened? _____

FAMILY AND SOCIAL HISTORY

List those who live within your home and their relationships to your child. Begin with parents, other children in order of their birth, oldest first, then others within the home. Please also list siblings outside the home.

Name	Age	Relationship	Occupation	Education

Have there been any: ☐ Separations ☐ Divorces ☐ Remarriages
Did any of these changes seem to have an effect on your child's behavior? ☐ Yes ☐ No

_____

How does your child get along with her/his family? (Specifically closest and most conflictual)

_____

_____

_____

Do any members or close relations have any problems with: ☐ Physical illness ☐ Mental illness

Please explain. _____
Is there much disagreement in/between the home(s) over discipline or rewards? ☐ Yes ☐ No

Please explain. _____
Has your child witnessed or been the victim of domestic violence in the home? ☐ Yes ☐ No

Please describe. _____
How are the children disciplined in your home?

_____

_____

Do you find it to be effective? ☐ Yes ☐ No
Has your child ever been emotionally, physically or sexually abused? ☐ Yes ☐ No

Please explain: _____
Have there ever been any CPS involvement/removals from the home? ☐ Yes ☐ No

Please explain: _____
Has your child experienced any personal traumas? ☐ Yes ☐ No

Please explain: _____
Does your child have friends? ☐ Yes ☐ No
Do other children tease or reject your child? ☐ Yes ☐ No
Do they make friends easily? ☐ Yes ☐ No
Do they keep the same friends for very long periods? ☐ Yes ☐ No
Do they tend to change peer groups frequently? ☐ Yes ☐ No

Please describe: _____
Does your child date? ☐ Yes ☐ No
Are they allowed to spend the night with peers of the opposite sex? ☐ Yes ☐ No
Is your child sexually active? ☐ Yes ☐ No
Do you place time restrictions on your child's out of home activities? ☐ Yes ☐ No
Comments:

_____

_____

_____

MEDICAL HISTORY

Did your child have any illnesses or health problems? ☐ Yes ☐ No

_____

Has your child had any hospitalizations or surgeries? ☐ Yes ☐ No

_____

Has your child ever had a head injury? ☐ Yes ☐ No
Was there a loss of consciousness? Were they hospitalized? ☐ Yes ☐ No

_____

Has your child ever had a seizure or convulsion? ☐ Yes ☐ No

_____

Has your child ever taken any prescription medications not listed above? ☐ Yes ☐ No

Dates:	**Medication:**

EDUCATION

What is the highest grade your child has completed? _____
Have they dropped out? ☐ Yes ☐ No
What grades does your child usually earn?
English/Language_____ Mathematics_____ Sciences_____ History/Social Studies_____
Is this a change from earlier grades? ☐ Yes ☐ No When did it change? _____
Has your child ever failed a grade? ☐ Yes ☐ No Which grade? _____

Has your child ever been diagnosed with a learning disability? ☐ Yes ☐ No
Has your child ever been in special education or behavior disordered classes (LD or BD)? ☐ Yes ☐ No
Has your child ever had behavior problems in school (such as fighting)? ☐ Yes ☐ No

Please describe. (Onset/frequency)

_____

Has your child ever been truant (skipped school)? ☐ Yes ☐ No
Known reasons and activity while not in school: _____
Has your child been teased or bullied in school? ☐ Yes ☐ No
When/what over? _____
Are they a bully in school? ☐ Yes ☐ No
Do you feel your child is treated fairly in school?

_____

SUBSTANCE USE

I'm going to ask if your child has used any of the following to your knowledge. If so, try to estimate the age it began, types if needed, and the frequency:

Substance	YES	NO	Began	Types	Frequency
Cigarettes					
Alcohol					
Marijuana					
Synthetics					
Inhalants					
Hallucinogens					
Pills					
Snorted Drugs					
Injected Drugs					
Methamphetamines					

Has your child ever stolen to obtain any of these substances? ☐ Yes ☐ No
Has your child sold or transported substances or illegal goods to obtain any of these substances? ☐ Yes ☐ No
Has your child taken any of these substances to school or used at school? ☐ Yes ☐ No

PERSONALITY & INTERESTS

Please list your child's hobbies, strengths and interests: _____

_____

_____

Please explain and include comments about organized activities in school, church and community: _____

_____

_____

If there is additional information that you think is important for us to know in order to understand your child and her/his best interests, please describe: _____

_____

_____

COUNSELOR USE ONLY

Please make a brief statement regarding your impression of the caregiver's attitude toward their child and the legal/ diagnostic process during the interview: _____

_____

_____