MOOD DISORDERS CENTER QUESTIONNAIRE-CHILD

Lucio Bini Mood Disorders Center
245 East 50th Street, Suite 2A
New York, NY 10022
Tel (212) 644-3111
Fax (212) 644-3119

Allergies: ___________________________________
Emergency contact: ___________________________
Today's date: ________________________________

Patient's Name____
Date of birth ____/____/________ Gender_____ Current Age ____________________
Address____
City____ State ________ZIP______-______

Completed by :(Name) ____
Relationship to Patient: ____
Address (if different from above) ____
City______________________________________State________ZIP________-_______

E-mail_______________@______________ Tel Home (_____)_____-________________

Tel Work (_____)______-_______________Cellular (_____)______-________________

Others who live in home: Name Date of Birth Relationship

____
____
____

(__ Check here if you have listed others on back)

Current Pediatrician__________________________________ Tel (____) ____-________
Address: ____
Medical History (Including Allergies): __Check here if there is more on back of page.

____
____

Neurological History: Head trauma_________ When _____________ Loss of Consciousness_____
Seizure Disorder ______ When _____________ Loss of Consciousness_____
Other: ____

School History: Current School _____________ ______________ Type of school_________________
Address____
Teacher's name and phone number ____
Previous schools attended: ____

PAST PSYCHIATRIAC DIAGNOSES: (check all that apply):

___ Attention Deficit ___ with hyperactivity or ___ without hyperactivity

___ Bipolar Disorder

___ Separation Anxiety Disorder

___ Conduct Disorder (CD)

___ Learning Disability

___ Major Depression

___ Dysthymia

___ Eating Disorder

___ Panic Disorder

___ Post Traumatic Stress Disorder (PTSD)

___ School Phobia

___ Pervasive Developmental Disorder (PDD)

___ Mental Retardation

___Aspergers Syndrome

___ Oppositional/Defiant Disorder (ODD)

___ Tourettes Syndrome

___ Psychosis

___ Schizophrenia

___ Personality Disorder

___ Schizoaffective Disorder

___ Obsessive/Compulsive Disorder (OCD)

___ Generalized Anxiety Disorder (GAD)

___ Social Phobia

___ Autism

___ None

___Other: ____

CURRENT PSYCHIATRIC DIAGNOSES:

____

____

FAMILY HISTORY

Family Index of Risk for Mood (FIRM)

Please indicate whether any of your (blood) relatives have had any of these concerns:

	Grandparents	Parents	Aunts/Uncles	Brothers/Sisters	Children (other than the child in this study)
Suicide	☐	☐	☐	☐	☐
Alcohol/Drug Problems	☐	☐	☐	☐	☐
Mental Hospital	☐	☐	☐	☐	☐
Depression Problems	☐	☐	☐	☐	☐
Manic or Bipolar	☐	☐	☐	☐	☐

Has a health professional ever told you that you have manic-depressive illness or bipolar disorder? Yes No

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CURRENT TREATMENT, including all medications:

Current Medication ________________________Started_______________
Dose______________ How taken___________ Blood Levels___________
Target symptoms____
Response____
Side effects____

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Dose______________ How taken___________ Blood Levels___________
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Current Medication ________________________Started_______________
Dose______________ How taken___________ Blood Levels___________
Target symptoms____
Response ____
Side effects____

PERINATAL HISTORY

Pregnancy: Events (bleeding, eclampsia, etc.)____
Use of Prescription Medications? ____
Alcohol: ______ (If yes) How much? ______How often? _______ How long?_________
Drugs________ (If yes) How much? ______How often? _______ How long?_________
Tobacco______ (If yes) How much? ______How often? _______ How long?_________

Labor: Spontaneous? ___; Induced with __________; Duration: _______; Fetal Distress________
Merconium reported? _____; Child jaundiced? _____; Extended Hospitalization? ________

Delivery: Week ____; Vaginal _____; C-section _____; Wt. _____Length _______Color _________

Apgar scores: 1’________ 5’________

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INFANCY and CHILDHOOD

Please mark all that applies (or has applied) to your child. (Indicate in months as 3m= 3 months; and years as 3 = 3 years.) Don't know (D/K) is OK.

Age (in months) when your child first: Smiled _____; Held Up Head _____; Turned Over ___; Crawled ___; Walked___; Ran ___; Spoke first word ____; Spoke a sentence _____;Used language to meet own needs ____.

Symptoms of Infancy (in months and years):

Indicate the age (month and/or years) when you first observed the symptom, and when it was first treated). Please write: NA = not applicable; D/C = don't know exact age; N/T if never treated.

Symptom	First Observed	First Treated
Clingy		
Separation anxiety		
Shy		
Uneasy		
Poor eater		
Fearful		
Colicky		
Fussy		
Intense emotions		
Poor sleeper		
Wakes-up often		
Hard to settle		
Inconsolable		
Temper tantrums		
Irritable		
Excitable		
Likes stimulation		
Oversensitive		
Startles		
Easily annoyed		
Over-reactivity		
Feisty, aggressive		
Strong willed		
Restless/hyperactive		
Energetic		
Physically strong		
Precocious		
Loud		
Cries a lot		
Social Anxiety		
Other		

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CHILDHOOD AND ADOLESCENCE (3-18)

Please mark all that applies (or has applied) to your child.
Indicate the age when you first observed the symptom, and when it was first treated.
Please write: NA if not applicable; D/C if don't know exact age; N/T if never treated

Symptom	First Observed	First Treated (in years)
General:		
Headaches		
Migraine headaches		
Multiple physical complaints		
Ear infections		
Gastrointestinal symptoms:		
Cramps		
Diarrhea		
Nausea		
Vomiting		
Indigestion		
Sleep:		
Trouble falling asleep		
Fights going to sleep		
Needs little sleep		
Never naps		
Irritable after naps		
Interrupted sleep		
Nightmares		
Night terrors		
Trouble waking up		
Sleepwalking		
Increased sleep		
Decreased sleep		
Bedwetting		
Likes white noise		
Fixed bedtime routine		
Diurnal mood variations:		
Likes to stay up late		
More alert, energetic in the afternoon		
Irritable, dull, groggy in the morning		
Poor appetite in the morning, good in the afternoon		
Appetite and weight:		
Weight varies a lot		
Appetite varies a lot		
Cravings for sweets/carbohydrates		
Cravings for salty foods		
Antisocial & Oppositional Behavior:		
Lack of remorse for wrongdoing		
Fire starting		
Mischievous		

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Lies or steals for reward		
Defiant of/opposes authority		
Truant, ignores curfews		
Fights with weapon		
Fights without weapon		
Gang membership		
Theft without victim confrontation (ex. shoplifting)		
Theft with victim confrontation (ex. purse snatching)		
Legal difficulties		
Criminal behavior		
Cognitive:		
Daydreaming		
Vivid imagination		
Racing/crowded thoughts		
Unable to concentrate		
Distractible		
Inattentive		
Disorganized		
Inefficient		
Inconsistent		
Depressed:		
Sadness, low self esteem, boredom, rarely smiles		
Pensive, melancholic, voices self-blame or criticism, guilt		
Puts himself down		
Blames self		
Euphoric:		
Giddy, silly, jokes, smiles		
Grandiose, pompous, self-important		
Euphoric mood (brief)		
Euphoric mood (extended)		
Irritable/Dysphoric:		
Upset		
Dissatisfied		
Temper tantrums		
Angry		
Hostile		
Distrustful		
Resentful		
Touchy		
Short-tempered		
Critical		
Argumentative		
Irritable mood (brief)		
Irritable mood (extended)		
Dysphoric, sad mood (brief)		
Dysphoric, sad mood (extended)		

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Aggression:		
Stubborn, rigid, willful		
Demanding, want things their way		
Blames, belittles others		
Domineering, bullies, intimidates others		
Makes threats or is verbally abusive		
Destruction of property		
Harm to pets		
Multiple physical fights/injuries (due to fights)		
Runs away overnight		
Impulse Control;		
Lies impulsively		
Drug use/abuse, alcohol use/abuse		
Running away from home		
Unable/unwilling to wait turn		
Intrusive and inappropriate		
Promiscuity (social, sexual)		
Daredevil behaviors		
Multiple physical trauma		
Shoplifting		
Reactivity;		
Excitable		
Likes stimulation		
Oversensitive		
Startles		
Easily annoyed		
Over-reactivity		
Cannot calm down easily		
Anxiety;		
Afraid of separating from parent/ caretaker		
Reports overwhelming anxiety/panic		
Fearful of darkness		
Fearful of insects		
Fearful of animals		
Fearful of heights		
School Phobia		
Social Phobia		
Obsessive traits (describe)		
Compulsive traits (describe)		
Other fears		
History of trauma;		
Please describe trauma(s)		
Remembers vividly trauma		
Recurrent dreams of trauma		
Flashbacks of trauma		

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Activity:		
Talks fast		
Talks non stop		
Loud		
Interrupts others		
Blurts out comments		
Rushed answers to questions		
Fidgety		
Unable to sit still		
Constantly leaves seat in class		
Increased energy level		
Busy; ‘On the go’		
Hyperactive		
Restless; Agitated		
Wild; Risk-taking behavior		
Mute		
More withdrawn than usual		
Severe fatigue		
Psychosexual:		
Age at first menstruation (if applicable)		
Precocious sexual interest		
Sexual self-stimulation		
Sexual behavior		
Uses sexually explicit language		
Eating disorder:		
Anorexia		
Bulimia		
Binge eating		
Weight varies a lot		
Appetite varies a lot		
Cravings for sweets, carbohydrates		
Cravings for salty food		
Self-harm:		
Morbid thoughts		
Death wishes		
Voiced suicidal ideation		
Made suicidal threats		
Self harm acts		
Attempted suicide		
Insight and Judgment:		
Denies illness		
Poor judgment		
Noncompliance		
Psychosis:		
Grandiose delusions: possess some special powers or knowledge		
Paranoid delusions: persecution, abuse, mistreatment, punishment		
Depressive delusions: guilt, ruin, sin		

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Nihilistic delusions: death, annihilation, morbid, hypochondriac		
Hallucinations: Auditory, Visual, Olfactory, Tactile, Taste, Movement		
Disorganized or extremely agitated behavior		
Talking incoherently, repeating words/sounds		
Bizarre behaviors (soiling self and other unusual behavior around bodily functions)		
Self-harm secondary to delusional ideation or command hallucinations		
Violent behavior towards objects, pets, Others		
Bizarre rituals and compulsive activities		
Odd or strange behavior (describe)		
Tics:		
Verbal		
Motor		
Other		

TEMPER TANTRUMS

Describe your child’s behavior during a temper tantrum/rage/meltdown, including physical changes: ____
____
____

Changes in facial expression ____
Crying ____
Loud/screaming ____
Aggressive/violent behavior____
How quickly does child go from being calm to being at his worst (most upset)? ___________
How quickly does the child go from being at his worst/upset to being calm again? _________

DURATION OF SYMPTOMS

Please describe (circle) the usual duration of:

Rages <15’ <1hr <6hr <24hr <3d <1wk <1mo <1y >1y
Average number of episodes (note per day/week/month)________
Anxiety <15’ <1hr <6hr <24hr <3d <1wk <1mo <1y >1y
Average number of episodes ______________________________
Sadness <15’ <1hr <6hr <24hr <3d <1wk <1mo <1y >1y
Average number of episodes ______________________________
Restlessness <15’ <1hr <6hr <24hr <3d <1wk <1mo <1y >1y
Average number of episodes ______________________________
Giddiness <15’ <1hr <6hr <24hr <3d <1wk <1mo <1y >1y
Average number of episodes ______________________________
Psychosis <15’ <1hr <6hr <24hr <3d <1wk <1mo <1y >1y
Average number of episodes ______________________________

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ONSET (____ check here if continued on back)
Describe the onset of symptoms:
Gradual, subtle ___________________________
Acute, sudden ___________________________
Describe any precipitant: ____
Onset while child was on medication?_____ If so, which one? ______
Length of time on medication____
Describe the main symptoms at onset: _____________________________________
____
____
____
Action taken: ____
____
____

CYCLING
Overall, how often does your child's mood change, or how often does a mood (i.e. rage) cause disability?

More than daily____
Daily____
More than weekly____
Weekly____
Biweekly____
Monthly____
Bimonthly____
Seasonally____
Other ____
Is there a pattern to your child's cycling? Please describe: ______________________
____
____
____
____
____

STRENGTHS
Describe your child's strengths, gifts and natural talents and how they are expressed:
____
____
____
____
____
____
____
____

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TREATMENT HISTORY

Age of:

Onset of symptoms that caused you to be concerned or alarmed _______________
Initial consultation with medical/mental health professional ____________________
Onset of treatment (psychological/pharmacological/other) ____________________
Initial diagnosis given ____
List all diagnoses given ____
____
Number of medical/mental health professional consulted *prior* to current diagnosis:
MD______ Ph.D______ Psy.D ________ MSW______ Other_________________

Please list all *past* medications (if unsure, please call pharmacy for information):

Medication_____________________________ Age_______________
Dose____
Duration____
Response____
Side effects____

Medication_____________________________ Age_______________
Dose____
Duration____
Response____
Side effects____

Medication_____________________________ Age_______________
Dose____
Duration____
Response____
Side effects____

Medication_____________________________ Age_______________
Dose____
Duration____
Response____
Side effects____

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ADDITIONAL COMMENTS

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____
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____
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Thank you for participating. Please return the completed material to

Lucio Bini Mood Disorders Center
245 East 50th Street, Suite 2A
New York, NY 10023

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