

## Parental Questionnaire for Children and Adolescent First Appointments

If you have any questions, please contact us on tel. 06171 98 94 16 -100, fax: 06171 98 94 16 -110

ambulanz-kjp.oberursel@vitos-rheingau.de

**Vitos kinder- und jugendpsychiatrische Ambulanz Oberursel**

*You can return this questionnaire in a*

**Obere Zeil 2**

*window envelope.*

**61440 Oberursel**

*Please ensure sufficient postage has been paid!*

**First name of the child:** \_\_\_\_\_ **Name:** \_\_\_\_\_

Born on: \_\_\_\_\_ Post Code, place of residence: \_\_\_\_\_

Street: \_\_\_\_\_ Tel.: \_\_\_\_\_

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

Nationality: \_\_\_\_\_ Country of origin (if applicable): \_\_\_\_\_

**Referring paediatrician or GP:** \_\_\_\_\_

GP Address: \_\_\_\_\_

**Health insurance provider:**  Statutory  Private **Name of health insurance provider:** \_\_\_\_\_

Insured by: \_\_\_\_\_ Born: \_\_\_\_\_

**Has the child been to our child and adolescent psychiatry unit before?**

No  If yes →  Outpatient  Inpatient



**Who completed the questionnaire?**

Name and surname: \_\_\_\_\_ Completed on: \_\_\_\_\_

Father  Mother  If other, who? \_\_\_\_\_

It would be helpful to have the following information for a successful consultation. Rest assured that this information will be kept **strictly confidential!**

Please mark the box next to the most appropriate statement. For some questions, more than one answer may be applicable at the same time; other questions may not apply to the child at all. You can also leave questions unanswered. There may not always be an appropriate answer. In such cases, please write your answers in a few words in the appropriate blank lines.

Any further questions can be addressed on the date of the clinic appointment. **If possible, both parents should accompany the child for the initial examination.** This allows you, your child or adolescent to describe your concerns together and to find suitable developmental solutions together with the therapists.

**Thank you for your cooperation!**

First of all, we would like to get an overview of why you have come to us.

## I. Reasons for the appointment

1. **What are** your actual reasons for coming to our department? What behavioural or physical symptoms does the child display? *(Please describe in a few words)*

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2. Do you remember **when** the behaviour / physical symptoms first started to occur?

Very gradually, starting at the age of \_\_\_\_\_

Very suddenly, starting at the age of \_\_\_\_\_

3. **Did anything** happen which you believe might be connected to this?

No       Yes → What?

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4. **Is the** behaviour more or less frequent when the child is in certain places, at certain times of the day, in certain situations and / or in the presence of certain persons?

No

More frequent or greater, when:

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Less frequent or weaker, when:

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5. **For whom** is this behaviour of the child the biggest problem, who suffers most?

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6. So far, **how have** you reacted to the child's behaviour?

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7. **How did** other people, who are important to the child (other parent, grandparents, nursery-school teachers, school teachers, etc.) react to this behaviour?

8. **Who recommended our services?** What are your expectations?

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16. **Age of the mother at the birth of the child:** \_\_\_\_\_

17. Were there any postnatal complications?

No  Yes → Which? \_\_\_\_\_

18. **Was** the child breastfed?

No  Yes → How long for? \_\_\_\_\_

19. **Development** in the first year (easy baby, lots of crying, regurgitation, failure to thrive, sleep disorders)

\_\_\_\_\_

20. **Did the child** crawl?  No  Yes

21. **After how many months** did the child learn to walk? \_\_\_\_\_ months

22. **Was this followed** by any physio- or ergotherapeutic treatment / early support?

No  Yes → What and when? \_\_\_\_\_

23. **When did** the child learn to speak?

First words: \_\_\_\_\_ 2-3 word sentences: \_\_\_\_\_ Whole sentences: \_\_\_\_\_

23a **Does** your child make mistakes in pronunciation and / or grammar?  No  Yes

23b **Can** you have a two-way conversation with your child?  No  Yes

23c **Did** your child have speech therapy?

No  Yes, from: \_\_\_\_\_ to: \_\_\_\_\_ because of: \_\_\_\_\_

24. **Does** the child have poor eyesight?

No  Yes, wears glasses since: \_\_\_\_\_ because of: \_\_\_\_\_

25. **Has** your child **had** a hearing test?  No  Yes → When? \_\_\_\_\_

Does he/she have a hearing impairment?  No  Yes, in particular: \_\_\_\_\_

26. **Did** your child have any tantrums?  No  Yes, at the age of: \_\_\_\_\_

27. **When was** the child potty trained? \_\_\_\_\_

When did he/she become potty trained during the day? \_\_\_\_\_

When did he/she become dry through the night? \_\_\_\_\_

28. **Start** of puberty?

Has not yet reached puberty  At the age of: \_\_\_\_\_  First period at the age of: \_\_\_\_\_

29. **Does the child suffer** from a certain physical condition (seizures, etc.) or hereditary congenital diseases?

No  Yes → Since when, what kind? \_\_\_\_\_



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30. **Does the child take** medication regularly?

No  Yes → Which ones? \_\_\_\_\_

31. **Has the child** ever been admitted to hospital?

No  Yes → Age? Illness? Operation? \_\_\_\_\_

32. **Has the child** ever been in an accident?

No  Yes → When? Type of accident? \_\_\_\_\_

33. **What** childhood illnesses has the child had? \_\_\_\_\_

34. Were there any **vaccination incidents**?

\_\_\_\_\_

35. Is your child **intolerant** or allergic to medicines or substances?

No  Yes → If yes, which?  Penicillin  Gluten  Lactose  Other

\_\_\_\_\_

### III. Preschool - School

36. **Preschool attendance:**

At the age of: \_\_\_\_\_  Did not go to preschool because: \_\_\_\_\_

\_\_\_\_\_

37. **How is / was** his/her behaviour in preschool?

No problems  Did not want to leave the mother

There are / were problems because: \_\_\_\_\_

38. **Did the child attend** preschool up until starting school?  No  Yes

*Only if still a preschooler:*

39. **The child is currently at** the following preschool

Regular preschool  Special needs preschool  Preschool for speech impairment

Forest kindergarten etc.

Name and address of the preschool: \_\_\_\_\_

*If the child is not in school / preschool, you can skip questions 40 - 49.*

40. The child currently attends the following school / type of school:

Preschool  Primary school  Secondary modern school  Secondary school  Grammar school

Comprehensive school  Special needs school

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Name and address of the school:

\_\_\_\_\_

*As a comprehensive assessment of the child's family and social environment as well as his / her physical development are important, please answer the following questions.*

**41. Schooling:**

Attended school from the age of: \_\_\_\_\_ years      Early / late because of: \_\_\_\_\_

from ..... to ..... Type of school: ..... Location: .....

from ..... to ..... Type of school: ..... Location: .....

from ..... to ..... Type of school: ..... Location: .....

Did the child repeat a year?                                       Yes                       No

If yes, which one and why: .....

Did not attend school: From ..... to .....

Reason? .....

**42. Does the child like going to school?**

- Yes
- Goes regularly
- Not sufficiently challenged
- Often skips school
- Does not want to go
- Is often missing because
- Is often late
- Is often anxious about going to school
- Too challenging



**43. What particular school interests does the child have?**

\_\_\_\_\_

**44. What subjects does the child struggle with?**

\_\_\_\_\_

**45. Is there a risk the child might have to repeat the year?**

No     Yes, because: \_\_\_\_\_

**46. What in particular do the teachers point out with regard to the child's performance and / or behaviour?**

*Please describe in a few words:*

\_\_\_\_\_

What do they praise, where is it positive? \_\_\_\_\_

*Please describe in a few words:* \_\_\_\_\_

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47. **How satisfied are you with how the child does his/her homework?**

Please rate from 1 (very good) to 6 (failed): \_\_\_\_\_

- Must often be encouraged to do homework
- Dawdles, does not concentrate
- Sloppy work
- The child needs constant help
- Forgets to mention homework
- Often refuses to do homework



48. **How long** does homework take? \_\_\_\_\_

49. **Who supervises** the child during homework? \_\_\_\_\_

## IV. Free time - Friends - Abilities

50. **Is the child** in a children's group, youth group or club?

No  Yes, in: \_\_\_\_\_

51. **How would you rate** the child's contact with friends (outside preschool or school)?

- Plays with many children
- Has 1 or 2 good friends
- Has no friends
- Plays mainly with older children
- Plays mainly with younger children
- Has difficulties, because: \_\_\_\_\_



52. **What particular** penchants, hobbies does the child have?

\_\_\_\_\_



53. **Where do you see** the child's special abilities?

\_\_\_\_\_

54. **What does your child do in his/her free time?** My child:

- Meets up with friends
- Keeps busy with \_\_\_\_\_



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- Watches TV: For how many hours? \_\_\_\_\_
- Plays on the computer / games console: For how many hours? \_\_\_\_\_
- Plays with his/her mobile / smartphone: For how many hours? \_\_\_\_\_
- Spends a lot of time with adults
- Is bored

## V. Other problem areas

There are now questions about different areas where children and adolescents **may** experience difficulties or problems in our experience. Please also answer these questions so that we can get a comprehensive picture.

55. **Is the child** often restless and / or does he/she struggle to pay attention?

- No / particularly when (please describe the activity / game, if applicable)

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- Yes / since when? In what situations (at home, at school, free time)?

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56. **Is the child** often defiant, and does he/she often annoy adults or children?

- No
- Yes → In what situations and to whom?
  - Only at home towards mother / father / siblings
  - Only at school, towards students / teachers
  - During free time
  - Generally



57. **Does** the child sometimes wet him/herself during the day or at night?

- No
- Yes →  Was once dry for 6 consecutive weeks
  - Wets him/herself during the day, since: \_\_\_\_\_ approx.: \_\_\_\_\_ times per week
  - Wets him/herself during the night, since: \_\_\_\_\_ approx.: \_\_\_\_\_ times per week

Which medical examinations have taken place?

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- Took / takes what medication? \_\_\_\_\_

58. **Does** the child sometimes soil himself/herself during the day or at night?

- No
- Yes →  Soils him/herself during the day, since: \_\_\_\_\_ approx.: \_\_\_\_\_ times per week

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Soils him/herself during the night, since: \_\_\_\_\_ approx.: \_\_\_\_\_ times per week

Which medical examinations have taken place? \_\_\_\_\_

59. **Is the child** very aggressive or disobedient towards other people? By this we mean, for example, that he/she steals, often runs away, is involved in fights, uses objects to threaten others, deliberately damages other people's property, plays with fire, tortures animals, burgles, plays truant, has contact with the police, sexual assaults, etc.

No       Yes → *Please describe in a few words:* \_\_\_\_\_

60. Does the child **drink** alcohol?

No       Yes → What, how much and how often per week? \_\_\_\_\_

61. Does the child **smoke**?

No       Yes → How often and how many per week? \_\_\_\_\_

62. Does the child **take** anything (medication, drugs) to influence his/her mood or to get high?

No       Yes → What and how often/much per week? \_\_\_\_\_

63. Has there been a time when the child had a significant mood swing for a longer period of time?

No       Yes → since when, how long? \_\_\_\_\_

Sad, depressed

Always cross, irritated, discontented with everyone and everything

Shows no interest in most things

Unreasonably happy

Sleeps a lot / not enough

Has difficulty concentrating

Feels guilty

Feels worthless

*Please describe:* \_\_\_\_\_



64. **Does the child** often mention wanting to commit suicide or self-harm; or has the child deliberately self-harmed or attempted suicide?

No       Yes → Since when, how often? Please describe:

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65. **Is the child** very anxious or scared and/or is he/she sometimes panicky?

No       Yes → Since when, how long? \_\_\_\_\_



Physical symptoms, e.g. heart palpitations

Separation anxiety: From whom? \_\_\_\_\_

Scared that something is going to happen to someone: To whom? \_\_\_\_\_

Scared of certain things: \_\_\_\_\_

Scared of certain places, e.g. shops, lifts, crowds: \_\_\_\_\_

Worried that he/she will have a panic attack

Very anxious, agitated, nervous when with other people

*Please describe:* \_\_\_\_\_

66. **Do you notice** your child compulsively repeating things, being excessively controlling, or does he/she act in a disturbed manner after certain routines or mention having recurring thoughts?

No       Yes → Since when, how long? Please describe: \_\_\_\_\_

The child:

Is constantly washing his/her hands

Is always trying to control: \_\_\_\_\_

Keeps repeating: \_\_\_\_\_

Mentions ever-recurring thoughts, notions

Seems to worry more than the situation warrants:

What about? About whom? \_\_\_\_\_



67. **Do you** have the impression that the child is reminded of a very distressing or life-threatening event, that it was a victim of a violent act (serious bodily injury, sexual assault, rape, assault), a traffic accident or a natural disaster or that he/she has seen something like this happen to someone else?

No       Yes → When, what? Please describe: \_\_\_\_\_

68. **Has there** ever been a time when the child has had peculiar or unusual experiences, such as hearing or seeing things that other people did not notice?

No  Yes → When, what? Please describe:

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69. **If possible**, please provide the height and weight of the child: \_\_\_ cm \_\_\_ kg

70. **Are you** happy with the weight?

- Yes
- Weighs too little
- Has lost too much weight: \_\_\_ kg within: \_\_\_\_\_
- Weighs too much
- Has gained too much weight: \_\_\_ kg within: \_\_\_\_\_

71. **Are you** worried about the child's eating habits?

No  Yes → Since when? \_\_\_\_\_

The child:

- Eats too much
- Takes laxatives or diet pills
- Eats too little  Vomits after meals
- Binge eats or has periods of the "munchies"



72. **How many hours** of sleep does your child generally get?

Duration of sleep at night: \_\_\_\_\_

- Problems falling asleep
- Problems staying asleep
- Frequent waking up at night
- Nightmares



73. **Does the child often complain** about physical discomfort?

No  Yes → Since when, how often, in what situations? \_\_\_\_\_

The child has:

- Headaches: Frequency? \_\_\_\_\_
- Stomach aches, nausea, vomiting: Frequency? \_\_\_\_\_

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Ticks (blinking, shaking of head, shoulder shrugging, grimacing, constant clearing of throat, etc.) Frequency? \_\_\_\_\_

Vomits after meals

Other complaints: \_\_\_\_\_

74. **In the space below** please mention anything you deem of importance, about which we have not asked any questions.

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## VI. Family situation

75. **Name of the father** / Date of birth: \_\_\_\_\_

Education / Further education: \_\_\_\_\_

Current job: \_\_\_\_\_

76. **Name of the mother** / Date of birth: \_\_\_\_\_

Education / Further education: \_\_\_\_\_

Current job: \_\_\_\_\_

77. **Family situation:**

Mother and Father married since: \_\_\_\_\_

Mother/Father deceased since: \_\_\_\_\_

Mother/Father ill, disabled: \_\_\_\_\_

Separated / divorced since: \_\_\_\_\_

**Custody is with:** \_\_\_\_\_

Remarried, who, since? \_\_\_\_\_

Child born out of wedlock: \_\_\_\_\_

Child was adopted at the age of: \_\_\_\_\_

Foster child, since: \_\_\_\_\_

Child lived in a home from: \_\_\_\_\_ to \_\_\_\_\_



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### 77a. Grandparents

- Mother of the father, age: \_\_\_\_\_ Contact:  Yes  No
- Father of the father, age: \_\_\_\_\_ Contact:  Yes  No
- Mother of the mother, age: \_\_\_\_\_ Contact:  Yes  No
- Father of the mother, age: \_\_\_\_\_ Contact:  Yes  No

### 78. Who has mainly raised the child?

- Mother  Father  Grandparents
- Or: \_\_\_\_\_

### 79. What other people live with the child in the same household and exert an influence on the child's upbringing?

\_\_\_\_\_

#### In the case of divorce or separation of the parents:

##### a) With whom does the child live?

- Mother  Father  Does not live with the parents, but with: \_\_\_\_\_

##### b) How often does the child have contact with the other parent?

- Not at all  Every \_\_\_\_\_ weeks or \_\_\_\_\_ times yearly

### 80. Who looks after the child when he/she gets home from preschool/school?

\_\_\_\_\_

### 81. Do the parents generally agree on how the child is brought up?

- Yes  Often disagree  Is not applicable as only one parent is raising the child

### 82. Does the child have to regularly do chores/work at home?

- No  Yes → Which? \_\_\_\_\_

### 83. Siblings:

Name / Date of birth \_\_\_\_\_

\_\_\_\_\_

School / Further education \_\_\_\_\_

\_\_\_\_\_



84. **Living conditions:**

Satisfactory: \_\_\_\_\_

Unsatisfactory, cramped conditions: \_\_\_\_\_

Child shares a room with: \_\_\_\_\_

Frequent moving: \_\_\_\_\_

85. **Financial situation:**  Satisfactory  Sufficient  Onerous

86. **Has any one** of the child's family ever been treated as an outpatient or clinically for anxiety, depression, eating disorders, alcohol or other psychological problems? Or did someone have these problems, but never seek help for them?

No  Yes → Who? (Please provide more details) \_\_\_\_\_

87. **Stress factors:** Are there or were there any stressful events that affect or affected your family? (such as illnesses, accidents or disabilities of relatives, death in the family...)

88.  No  Yes → Who? (Please provide more details)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## DECLARATION OF CONSENT

Sole parent

Joint parents

I agree to my child \_\_\_\_\_

being seen at the Vitos kinder- und jugendpsychiatrische Ambulanz Oberursel, Obere Zeil 2, 61440 Oberursel.

Date, signature of the mother entitled to custody: \_\_\_\_\_

Date, signature of the father entitled to custody: \_\_\_\_\_

*(Please note that we require the signature of **both** parents who have custody of the child)*

If the parents do not have custody of the child:

I agree to the child \_\_\_\_\_

being seen at the Vitos kinder- und jugendpsychiatrischen Wiesbaden, Eberleinstr. 48, 65195 Wiesbaden.

Date, signature of the person with custody of the child: \_\_\_\_\_

In order to ensure the proper care of your child, we generally send a report to the referring general practitioner (GP) or paediatrician.

We need your consent for this waiver from our duty of confidentiality:

## RELEASE FROM CONFIDENTIALITY

As guardian of the child: \_\_\_\_\_

I hereby release the employees of the outpatient department of the Rheinhöhe Clinic in Oberursel

from the obligation of confidentiality vis-a-vis the responsible GP/paediatrician.

Date, Place: \_\_\_\_\_

Signature: \_\_\_\_\_

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