





### Stressful Child Events:

Has your child been a victim of:

- |   |   |
|---|---|
| <input type="checkbox"/> Physical abuse                 | <input type="checkbox"/> Sexual abuse                     |
| <input type="checkbox"/> Emotional or verbal abuse      | <input type="checkbox"/> Harassment at school             |
| <input type="checkbox"/> Crime                          | <input type="checkbox"/> Bullying                         |
| <input type="checkbox"/> Witnessed violence in the home | <input type="checkbox"/> Witnessed crime in the community |
| <input type="checkbox"/> Not sure _____                 |   |

Has the child ever had a life-threatening experience (house fire, car accident, etc.)? \_\_\_\_\_

Has the child been separated from parents for more than a week (child or parent hospitalized, parent extended business trip, parent away caring for someone else, visiting relative or friend, camp)?

### Family History:

Indicate any relatives of the child with any of the following problems:

	Brothers Sisters	Natural Mother	Mother's Relatives	Natural Father	Father's Relatives
Obsessive-Compulsive disorder or fussy habits, picky, rigid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tics or other nervous habits, Tourette's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression for more than 2 weeks, medications for mood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide or attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychosis or schizophrenia, hospitalized for mental or emotional problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal problems, arrests, jail/prison time, court probations, "always in trouble"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serious or chronic medical problems: cancer, deafness, heart problems, seizures, diabetes, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gambling, shopping or other compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is there anything else we should know about your child or family? \_\_\_\_\_

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