

SOCIAL SKILLS DEVELOPMENT CENTER  
DEMOGRAPHIC FORM

The following information will allow us to better help you. Please answer all items. ALL INFORMATION PROVIDED WILL REMAIN IN THE STRICTEST PROFESSIONAL CONFIDENCE.

CAREGIVER 1 LAST NAME \_\_\_\_\_, FIRST NAME \_\_\_\_\_

CAREGIVER 2 LAST NAME \_\_\_\_\_, FIRST NAME \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_

TEEN LAST NAME \_\_\_\_\_, FIRST NAME \_\_\_\_\_

1. Teen Gender  Male  Female

2. Teen Racial Background:

- Caucasian  Latino/Hispanic  
 African American  Asian  
 Native American  Middle Eastern  
 Other (specify) \_\_\_\_\_

3. Caregiver Current Marital Status:

- Unmarried  Married  
 Separated  Divorced  
 Widowed  Living with partner

4. Children: Write in the name, sex, & birth date of each of your children. If adopted, put age at time of adoption.

Name	Sex	Birth Date
_____	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	_____

5. Does your teen have any problems with his/her behavior and/or academic adjustment in school?

Yes  No

Specify: \_\_\_\_\_

6. Is your teen in a special class of any kind?

Yes  No

Specify: \_\_\_\_\_

7. Caregiver Occupation: Please write in the kind of work you most usually do using a "job title".

\_\_\_\_\_

8. Number of hours per week employed: \_\_\_\_\_

9. Occupation of Spouse/Partner (even if separated/divorced).

\_\_\_\_\_

10. Number of hours per week employed: \_\_\_\_\_

11. Education: What were the highest levels in school or college completed? Or degrees obtained?

Yourself: \_\_\_\_\_

Spouse/Partner: \_\_\_\_\_

12. What is your goal for attending this program?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**SOCIAL SKILLS DEVELOPMENT CENTER  
MEDICAL SCREENING SUMMARY**

Patient Name: \_\_\_\_\_

Caregiver(s) Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

May we contact physician if needed?       Yes       No

Has your child had psychological treatment/therapy before?       Yes       No

Therapist Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

May we contact therapist if needed?       Yes       No

Reason(s) for attendance in program: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of School Patient Attends: \_\_\_\_\_ Grade: \_\_\_\_\_

Does your child have any medical condition(s)?       Yes       No

If yes, explain: \_\_\_\_\_

**GESTATIONAL HISTORY**

During this pregnancy did the mother have:	Yes	No	Describe:
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Elevated blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Measles	<input type="checkbox"/>	<input type="checkbox"/>	_____
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flu	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other virus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medical during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Threatened miscarriage or early contractions	<input type="checkbox"/>	<input type="checkbox"/>	_____

In the 6 months preceding this pregnancy did the mother have exposure to:

Drugs or alcohol       Yes       No      X rays       Yes       No

Describe: \_\_\_\_\_

\_\_\_\_\_

**PERINATAL HISTORY**

	Yes	No	Describe:
Child premature	<input type="checkbox"/>	<input type="checkbox"/>	_____
Complicated labor	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fetal distress	<input type="checkbox"/>	<input type="checkbox"/>	_____
Delayed crying	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breech, Caesarian or forceps delivery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Baby given oxygen or transfusion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Baby placed in incubator	<input type="checkbox"/>	<input type="checkbox"/>	_____
Baby remained in hospital after mother went home	<input type="checkbox"/>	<input type="checkbox"/>	_____

DEVELOPMENT HISTORY

Were there any problems or delays in your child's:	Yes	No	Describe:
Holding head up	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning to bond	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sitting alone	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning to crawl	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleeping through the night	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning to walk	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning to talk	<input type="checkbox"/>	<input type="checkbox"/>	_____
Toilet training	<input type="checkbox"/>	<input type="checkbox"/>	_____
Feeding self with spoon	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tying shoes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dressing self	<input type="checkbox"/>	<input type="checkbox"/>	_____
Writing name	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ability to make and get along with friends	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is your child adopted?	<input type="checkbox"/>	<input type="checkbox"/>	If so, at what age? _____
Has your child ever been physically abused?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has your child ever been neglected?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has your child ever witnessed domestic violence?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has your child ever had someone close to him or her die?	<input type="checkbox"/>	<input type="checkbox"/>	_____

SCHOOL HISTORY:

Name of school child attends: \_\_\_\_\_ Grade Level: \_\_\_\_\_

Address & phone number of school: \_\_\_\_\_

Has your child ever had:	Yes	No	Describe:
Problems getting along with teachers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Problems getting along with classmates	<input type="checkbox"/>	<input type="checkbox"/>	_____
Disruptive classroom behavior	<input type="checkbox"/>	<input type="checkbox"/>	_____
Suspensions/transfers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Special education	<input type="checkbox"/>	<input type="checkbox"/>	_____
Failing grades	<input type="checkbox"/>	<input type="checkbox"/>	_____
Truancy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Problems studying	<input type="checkbox"/>	<input type="checkbox"/>	_____
Special day classes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tutoring	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

OTHER HISTORY:

Has your child ever:	Yes	No	Describe:
Been in trouble with the law	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been removed from the family	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been in a gang	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been in foster care	<input type="checkbox"/>	<input type="checkbox"/>	_____
Used any weapons	<input type="checkbox"/>	<input type="checkbox"/>	_____
Experimented with sex or drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____

MEDICAL HISTORY:

Does your child have any allergies?  Yes  No Allergic to: \_\_\_\_\_

Name of your child's doctor: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

MEDICAL HISTORY (continued)

Has your child even been hospitalized?  Yes  No If so, reason: \_\_\_\_\_

Has your child had any of the following:	Yes	No	Describe:
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	_____
Measles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Polio	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Parasites	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Has your child had any of the following immunizations?  
 Polio  DTP  Measles  MMR (Measles, Mumps, Rubella)  Hepatitis B

Has your child had any of the following medical conditions?	Yes	No	Describe:
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness or fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthmas, Hay Fever, Hives, Rash	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgeries, serious illnesses, accidents	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy, convulsions, seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent, severe headache	<input type="checkbox"/>	<input type="checkbox"/>	_____
Back, muscle, joint problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis, Jaundice or Liver problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Soiling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision impairment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Does your child exhibit any of the following behaviors or problems?	Yes	No	Describe:
Problems with reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Problems with math	<input type="checkbox"/>	<input type="checkbox"/>	_____
Problems with writing skills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Problems expressing him/herself	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Problems understanding others	<input type="checkbox"/>	<input type="checkbox"/>	_____

Does your child exhibit any of the following behaviors or problems? (continued)

	Yes	No	Describe:
Inattentiveness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Aggression towards others	<input type="checkbox"/>	<input type="checkbox"/>	_____
Destruction of property	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stealing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lying	<input type="checkbox"/>	<input type="checkbox"/>	_____
Defiance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loses temper often	<input type="checkbox"/>	<input type="checkbox"/>	_____
Argues excessively	<input type="checkbox"/>	<input type="checkbox"/>	_____
Often breaks rules	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blames others for his/her mistakes & misbehaviors	<input type="checkbox"/>	<input type="checkbox"/>	_____
Uses drugs or alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tics	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unable to control bowels	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wets the bed	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has trouble being alone	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has trouble being away from home	<input type="checkbox"/>	<input type="checkbox"/>	_____
Refuses to talk	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appears depressed	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appears anxious or fearful	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep difficulties	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	_____
Problems expressing affection	<input type="checkbox"/>	<input type="checkbox"/>	_____
Obsesses about things	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cries easily/often	<input type="checkbox"/>	<input type="checkbox"/>	_____

Has your child been diagnosed with any of the following disorders? If yes, what year?

	Yes	No	Describe:
Attention Deficit Hyperactivity Disorder (ADHD or ADD)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech or language delays	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pervasive Development Disorder (PDD)	<input type="checkbox"/>	<input type="checkbox"/>	_____

**FAMILY HISTORY:**

Has anyone in your family had any of the following mental health conditions?

	Yes	No	Describe:
Drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Suicide threats or attempts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Completed suicide	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxiety Disorder/Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	_____
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Attention Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Manic Depression (Bipolar)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
Therapy or counseling	<input type="checkbox"/>	<input type="checkbox"/>	_____

Child's Name: \_\_\_\_\_

Completed By: \_\_\_\_\_

**Medication History Questionnaire**

- My child has never been on medications for behavior, mood, or attention (leave the rest of form blank).
- My child does not take medications at this time, but has in the past (please complete Part II).

**Part I.** If your child is currently taking prescription medication(s) for behavior, mood, or attention problems, please complete the following items for each medication your child is currently prescribed:

**Current prescription medication #1 --Name of Medication** \_\_\_\_\_

Total dosage taken per day \_\_\_\_\_ mg

Approximate Date Prescribed: \_\_\_\_\_ Approximate Date Discontinued \_\_\_\_\_

1. Please check all problems this medication was supposed to address (check all that apply):
- Inattention  Hyperactivity  Aggression  Tics  Poor Social Skills  Irritability  Obsessions
  - Poor Body Boundaries  Anxiety  Depressed Mood  Difficulty with Transitions  Explosiveness
  - not sure which of the above.
  - Other \_\_\_\_\_

2. AFTER prescribing the medication, how did the doctor check up on the problem later? Check all that apply:

- The doctor did not ask further questions.
- Asked parent about problem  Asked child about problem
- Asked child's teacher about problem  Had parent ask child's teacher about problem
- Gave parent a form to complete about problem  Gave child a form to complete about problem
- Gave child's teacher a form to complete about problem
- The doctor asked only about side effects, not improvement in problem.
- Other (please indicate how) \_\_\_\_\_

3. Who prescribed it?  Pediatrician  Psychiatrist  Neurologist  Other Physician

4. Was this physician your current prescribing physician?  Yes  No

Please consider the effectiveness of this medication in addressing the above problem(s), without regard for any side effects.

5. How effective was this medication INITIALLY in reducing problems in your child?

1	2	3	4	5	6	7
Ineffective			Not sure			Very effective

6. How effective was this medication AT THE PRESENT TIME in reducing problems in your child?

1	2	3	4	5	6	7
Ineffective			Not sure			Very effective

**Current prescription medication #2 -- Name of Medication** \_\_\_\_\_

Total dosage taken per day \_\_\_\_\_ mg

Approximate Date Prescribed: \_\_\_\_\_ Approximate Date Discontinued \_\_\_\_\_

1. Please check all problems this medication was supposed to address (check all that apply):
- Inattention  Hyperactivity  Aggression  Tics  Poor Social Skills  Irritability  Obsessions
  - Poor Body Boundaries  Anxiety  Depressed Mood  Difficulty with Transitions  Explosiveness
  - not sure which of the above.
  - Other \_\_\_\_\_

2. AFTER prescribing the medication, how did the doctor check up on the problem later? Check all that apply:

- The doctor did not ask further questions.
- Asked parent about problem  Asked child about problem
- Asked child's teacher about problem  Had parent ask child's teacher about problem
- Gave parent a form to complete about problem  Gave child a form to complete about problem
- Gave child's teacher a form to complete about problem

The doctor asked only about side effects, not improvement in problem.

Other (please indicate how) \_\_\_\_\_

3. Who prescribed it (check one)?  Same physician as Current medication #1  Pediatrician  Psychiatrist  
 Neurologist  Other Physician

4. Was this physician your current prescribing physician?  Yes  No

5. Why was this medication added to medication #1?  Medication #1 not effective enough  This medication addressed a different problem  Doctor did not specify  Do not recall

Other (please indicate) \_\_\_\_\_

Please consider the effectiveness of this medication in addressing the above problem(s), without regard for any side effects.

6. How effective was this medication INITIALLY in reducing problems in your child?

1                  2                  3                  4                  5                  6                  7  
 Ineffective    Not sure    Very effective

7. How effective was this medication AT THE PRESENT TIME in reducing problems in your child?

1                  2                  3                  4                  5                  6                  7  
 Ineffective    Not sure    Very effective

My child is prescribed \_\_\_\_\_ medications in addition to the above  
 Please list them \_\_\_\_\_

**Part II. Medications that your child has taken in the past.** Please begin with the MOST RECENT medication that was discontinued and work backwards in time.

Past Medication #1 – Name of Medication \_\_\_\_\_ Total dosage taken per day \_\_\_\_\_ mg  
 Approximate Date Prescribed: \_\_\_\_\_ Approximate Date Discontinued \_\_\_\_\_

1. Please check all problems this medication was supposed to address (check all that apply):

- Inattention  Hyperactivity  Aggression  Tics  Poor Social Skills  Irritability  Obsessions  
 Poor Body Boundaries  Anxiety  Depressed Mood  Difficulty with Transitions  Explosiveness  
 not sure which of the above.  
 Other \_\_\_\_\_

2. AFTER prescribing the medication, how did the doctor check up on the problem later? Check all that apply:

- The doctor did not ask further questions.  
 Asked parent about problem  Asked child about problem  
 Asked child's teacher about problem  Had parent ask child's teacher about problem  
 Gave parent a form to complete about problem  Gave child a form to complete about problem  
 Gave child's teacher a form to complete about problem  
 The doctor asked only about side effects, not improvement in problem.  
 Other (please indicate how) \_\_\_\_\_

3. Who prescribed it?  Pediatrician  Psychiatrist  Neurologist  Other Physician

4. Was this physician your current prescribing physician?  Yes  No

5. Why was the medication discontinued?  Side effects were problematic  Medication no longer effective  
 Doctor recommended a change to increase effectiveness  Doctor did not specify  Do not recall  
 Other (please indicate) \_\_\_\_\_

Please consider medication effectiveness at addressing the above problem(s), without regard for any annoying or unbearable side effects.

6. How effective was this medication INITIALLY in reducing problems in your child?

1                  2                  3                  4                  5                  6                  7  
 Ineffective    Not sure    Very effective





Child Name: \_\_\_\_\_

Date: \_\_\_\_\_

Completed By:  Mother  Father  Other: \_\_\_\_\_

**BARKLEY PARENT QUESTIONNAIRE**  
(from Barkley Parent Interview)

Please answer the following to the best of your knowledge:

School name: \_\_\_\_\_

**SCHOOL HISTORY**

School Performance/Behavior

At any time has your child: (CHECK BOX, IF APPLICABLE, FOR EACH GRADE LEVEL)

GRADE LEVEL >>>	P	K	1	2	3	4	5	6	7	8	9	10	11	12
Undergone an IEP (school)														
Had Spec. Education Services														
Been labeled LD														
Worked below potential														
Failed a subject														
Repeated a grade														
Had ADHD problems														
Was defiant/argumentative														
Been suspended														
Been expelled														
Had peer problems														

Current Educational Program

1. What is your child's current grade level? \_\_\_\_\_

2. Is child now receiving Special Education Services? NO YES  
If yes, what type? (check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Resource room (part time)          | <input type="checkbox"/> Speech/language therapy      |
| <input type="checkbox"/> Shadow or Aide                     | <input type="checkbox"/> School counseling            |
| <input type="checkbox"/> Occupational therapy               | <input type="checkbox"/> Behavior disorders classroom |
| <input type="checkbox"/> Self-contained LD room (full time) | <input type="checkbox"/> Physical therapy             |
| <input type="checkbox"/> Social skills group therapy        | <input type="checkbox"/> Other _____                  |

**FAMILY HISTORY**

Custody of child is held (if applicable):

- jointly  other \_\_\_\_\_
- by mother only
- by father only
- by state

**Psychiatric/Medical Characteristics of Biological Relatives**

(CHECK ALL THAT APPLY) >>> Past/present history of the following in your family:	Siblings	Mother	Father	Extended (Maternal)	Extended (Paternal)
1. Short attention, distractibility, hyperactivity					
2. Defiant, rebellious, oppositional					
3. Lying, fighting, stealing, breaking rules					
4. Antisocial behavior					
5. Learning Disabilities or language difficulty					
6. Mental Retardation					
7. losing touch with reality					
8. Manic-depression					
9. Depression or suicide/attempted suicide					
10. "Nervous breakdown"					
11. Excessive fears (Phobias)					
12. Motor + vocal tics; Tourettes					
13. Alcohol abuse					
14. Substance abuse					
15. Physical abuse					
16. Sexual abuse					
17. Seizures/epilepsy					
18. Other medical					
19. Other psychiatric					
20. Outpatient psychiatric services					
21. Inpatient psychiatric services					

**Lifestyle Changes/Psychosocial Stressors (in the past 6 months-1 year)**

(Check all that apply)

- Pregnancy
- Change in work schedule
- New sibling
- Change in residence
- Marriage
- Change in school placement
- Severe marital tensions
- Job termination/layoff

- Separation/divorce
- Serious financial strains
- Health problems
- Serious legal problems
- Death of close relative/friend
- Psychiatric problems
- Other \_\_\_\_\_

Scored: \_\_\_\_\_  
 Verified: \_\_\_\_\_  
 Entered: \_\_\_\_\_

Pre Post  
 Name: \_\_\_\_\_  
 Date: \_\_\_\_\_

### Quality of Socialization Questionnaire – Parent (QSQP-Revised)

We are interested in get-togethers that your teen had in the last month with other teens about the same age. A get-together is any time that teens follow through with a commitment to meet together after agreeing on a place and time.

- It may be a planned activity, such as bowling or at the video arcade or just to “hang out”.
- It may be organized well in advance or organized spontaneously for later the same day.
- It may be with one other teen or a group of teens.

Please answer the following questions about your teen’s get-togethers.

**1. Get-togethers your teen organized with another teen or other teens:** How many get-togethers were organized by your teen in the past month: \_\_\_\_\_

Please give the **first names** of the friends that attended a get-together organized by your teen in the past month. If your teen did not organize a get-together in the past month, leave the section below blank.

Friend’s first name \_\_\_\_\_  
 Friend’s first name \_\_\_\_\_  
 Friend’s first name \_\_\_\_\_  
 Friend’s first name \_\_\_\_\_

Friend’s first name \_\_\_\_\_  
 Friend’s first name \_\_\_\_\_  
 Friend’s first name \_\_\_\_\_  
 Friend’s first name \_\_\_\_\_

**2. Get-togethers at your home when you were present or that you chaperoned and were able to observe:** At the last get-together your teen organized, when you could see or hear what was happening, how did the teens get along? Circle the number below that describes how true each sentence is.

	<i>Not at all true</i>	<i>Just a little true</i>	<i>Pretty much true</i>	<i>Very much true</i>
They didn’t share games, personal items, etc.	0	1	2	3
They got along well	3	2	1	0
They got upset at each other	0	1	2	3
They had fun	3	2	1	0
They argued with each other	0	1	2	3
They enjoyed each other	3	2	1	0
They criticized or teased each other	0	1	2	3
They shared conversation	3	2	1	0
They were bossy with each other	0	1	2	3
They needed a parent to solve problems	0	1	2	3
They withdrew from each other	0	1	2	3
They annoyed each other	0	1	2	3

**3. Get-togethers your teen was invited to by another teen or other teens:** How many get-togethers was your teen invited to by others in the past month: \_\_\_\_\_

Please give the **first names** of the teens who invited your teen to the get-togethers. If your teen did not attend a get-together organized by another teen in the past month, leave the section below blank.

Friend’s first name \_\_\_\_\_  
 Friend’s first name \_\_\_\_\_  
 Friend’s first name \_\_\_\_\_  
 Friend’s first name \_\_\_\_\_

Friend’s first name \_\_\_\_\_  
 Friend’s first name \_\_\_\_\_  
 Friend’s first name \_\_\_\_\_  
 Friend’s first name \_\_\_\_\_

Scored: \_\_\_\_\_

Pre Post

Verified: \_\_\_\_\_

Name: \_\_\_\_\_

Entered: \_\_\_\_\_

Date: \_\_\_\_\_

Please rate your child's behavior below. Please note: If your child is currently taking medication please answer the questions below according to your child's behavior when they are off the medication.

### SNAP-IV RATING SCALE

James M. Swanson, Ph.D

Check the column which best describes this child:

	Not at All	Just a Little	Pretty Much	Very Much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities				
2. Often has difficulty sustaining attention in tasks or play activities				
3. Often does not seem to listen when spoken to directly				
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)				
5. Often has difficulty organizing tasks and activities				
6. Often avoids, dislikes, or has difficulties engaging in tasks that require sustained mental effort (such as schoolwork or homework)				
7. Often loses things necessary for tasks or activities ( e.g., school assignments, pencils, books, tools, or toys)				
8. Is often easily distracted by extraneous stimuli				
9. Often forgetful in daily activities				

10. Often fidgets with hands or feet, squirms in seat				
11. Often leaves seat in classroom or in other situations in which remaining seated is expected				
12. Often runs about or climbs excessively in situations where it is inappropriate				
13. Often has difficulty playing or engaging in leisure activities quietly				
14. Is always "on the go" or acts if "driven by a motor"				
15. Often talks excessively				
16. Often blurts out answers to questions before the questions have been completed				
17. Often has difficulty awaiting turn				
18. Often interrupts or intrudes on others (e.g., butts into other's conversations or games)				

19. Often loses temper				
20. Often argues with adults				
21. Often actively defies or refuses adult requests or rules				
22. Often deliberately does things that annoy other people				
23. Often blames others for his or her mistakes or misbehavior				
24. Often touchy or easily annoyed by others				
25. Is often angry and resentful				
26. Is often spiteful or vindictive				

**Office Use Only:**

Total item ratings = \_\_\_\_\_/9

\_\_\_\_\_/9

\_\_\_\_\_/8

Avg rating per item = \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Scored: \_\_\_\_\_

Pre Post

Verified: \_\_\_\_\_

Name: \_\_\_\_\_

Entered: \_\_\_\_\_

Date: \_\_\_\_\_

## AQ

### How to fill out the questionnaire

*Below is a list of statements about your child. Please read each statement very carefully and rate how strongly you agree or disagree by selecting the appropriate option opposite each question.*

**DO NOT MISS ANY STATEMENT OUT.**

#### *Examples*

E1. S/he is willing to take risks.	definitely agree	slightly agree	<input checked="" type="radio"/> slightly disagree	definitely disagree
E2. S/he likes playing board games.	definitely agree	<input checked="" type="radio"/> slightly agree	slightly disagree	definitely disagree
E3. S/he finds learning to play musical instruments easy.	definitely agree	slightly agree	slightly disagree	<input checked="" type="radio"/> definitely disagree
E4. S/he is fascinated by other cultures.	<input checked="" type="radio"/> definitely agree	slightly agree	slightly disagree	definitely disagree

	Definitely Agree	Slightly Agree	Slightly Disagree	Definitely Disagree
1. S/he prefers to do things with others rather than on her/his own.				
2. S/he prefers to do things the same way over and over again.				
3. If s/he tries to imagine something, s/he finds it very easy to create a picture in her/his mind.				
4. S/he frequently gets so strongly absorbed in one thing that s/he loses sight of other things.				
5. S/he often notices small sounds when others do not.				
6. S/he usually notices car number plates or similar strings of information.				
7. Other people frequently tell her/him that what s/he has said is impolite, even though s/he thinks it is polite.				
8. When s/he is reading a story, s/he can easily imagine what the characters might look like.				
9. S/he is fascinated by dates.				
10. In a social group, s/he can easily keep track of several different people's conversations.				
11. S/he finds social situations easy.				
12. S/he tends to notice details that others do not.				
13. S/he would rather go to a library than a party.				
14. S/he finds making up stories easy.				
15. S/he finds her/himself drawn more strongly to people than to things.				

	Definitely Agree	Slightly Agree	Slightly Disagree	Definitely Disagree
16. S/he tends to have very strong interests, which s/he gets upset about if s/he can't pursue.				
17. S/he enjoys social chit-chat.				
18. When s/he talks, it isn't always easy for others to get a word in edgeways.				
19. S/he is fascinated by numbers.				
20. When s/he is reading a story, s/he finds it difficult to work out the characters' intentions.				
21. S/he doesn't particularly enjoy reading fiction.				
22. S/he finds it hard to make new friends.				
23. S/he notices patterns in things all the time.				
24. S/he would rather go to the theatre than a museum.				
25. It does not upset him/her if his/her daily routine is disturbed.				
26. S/he frequently finds that s/he doesn't know how to keep a conversation going.				
27. S/he finds it easy to "read between the lines" when someone is talking to her/him.				
28. S/he usually concentrates more on the whole picture, rather than the small details.				
29. S/he is not very good at remembering phone numbers.				
30. S/he doesn't usually notice small changes in a situation, or a person's appearance.				
31. S/he knows how to tell if someone listening to him/her is getting bored.				



	Definitely Agree	Slightly Agree	Slightly Disagree	Definitely Disagree
32. S/he finds it easy to do more than one thing at once.				
33. When s/he talks on the phone, s/he is not sure when it's her/his turn to speak.				
34. S/he enjoys doing things spontaneously.				
35. S/he is often the last to understand the point of a joke.				
36. S/he finds it easy to work out what someone is thinking or feeling just by looking at their face.				
37. If there is an interruption, s/he can switch back to what s/he was doing very quickly.				
38. S/he is good at social chit-chat.				
39. People often tell her/him that s/he keeps going on and on about the same thing.				
40. When s/he was younger, s/he used to enjoy playing games involving pretending with other children.				
41. S/he likes to collect information about categories of things (e.g. types of car, types of bird, types of train, types of plant, etc.).				
42. S/he finds it difficult to imagine what it would be like to be someone else.				
43. S/he likes to plan any activities s/he participates in carefully.				
44. S/he enjoys social occasions.				
45. S/he finds it difficult to work out people's intentions.				
46. New situations make him/her anxious.				

	<b>Definitely Agree</b>	<b>Slightly Agree</b>	<b>Slightly Disagree</b>	<b>Definitely Disagree</b>
47. S/he enjoys meeting new people.				
48. S/he is a good diplomat.				
49. S/he is not very good at remembering people's date of birth.				
50. S/he finds it very to easy to play games with children that involve pretending.				

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Scored: \_\_\_\_\_  
Verified: \_\_\_\_\_  
Entered: \_\_\_\_\_

Pre Post  
Name: \_\_\_\_\_  
Date: \_\_\_\_\_

**SAS-A (Parent)**  
La Greca, 1998

Please answer each of the items regarding YOUR CHILD'S feelings and behavior. There are no right or wrong answers. Please answer as honestly as you can.

Use these numbers to show HOW MUCH each statement IS TRUE FOR YOUR CHILD:

- 1 = Not at all
- 2 = Hardly ever
- 3 = Sometimes
- 4 = Most of the time
- 5 = All the time

1. My child worries about doing something new in front of others.

1                      2                      3                      4                      5  
Not at all      Hardly ever      Sometimes      Most of the time      All of the time

2. My child likes to do things with his/her friends.

1                      2                      3                      4                      5  
Not at all      Hardly ever      Sometimes      Most of the time      All of the time

3. My child worries about being teased.

1                      2                      3                      4                      5  
Not at all      Hardly ever      Sometimes      Most of the time      All of the time

4. My child feels shy around people he/she doesn't know.

1                      2                      3                      4                      5  
Not at all      Hardly ever      Sometimes      Most of the time      All of the time

5. My child only talks to people he/she knows really well.

1                      2                      3                      4                      5  
Not at all      Hardly ever      Sometimes      Most of the time      All of the time

6. My child feels that peers talk behind his/her back.

1                      2                      3                      4                      5  
Not at all      Hardly ever      Sometimes      Most of the time      All of the time

7. My child likes to read.

1                      2                      3                      4                      5  
Not at all      Hardly ever      Sometimes      Most of the time      All of the time

8. My child worries about what others think of him/her.

1                      2                      3                      4                      5  
Not at all      Hardly ever      Sometimes      Most of the time      All of the time

9. My child is afraid that others will not like him/her.

1                      2                      3                      4                      5  
Not at all      Hardly ever      Sometimes      Most of the time      All of the time

10. My child gets nervous when talking to peers he/she doesn't know very well.

1                      2                      3                      4                      5  
Not at all      Hardly ever      Sometimes      Most of the time      All of the time

11. My child likes to play sports.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

12. My child worries about what others say about him/her.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

13. My child gets nervous when meeting new people.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

14. My child worries that others don't like him/her.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

15. My child is quiet when he/she is with a group of peers.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

16. My child likes to do things by him/herself.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

17. My child feels that others make fun of him/her.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

18. If my child gets into an argument with another person, my child worries that the other person will not like him/her.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

19. My child is afraid to invite others to do things with him/her because they might say no.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

20. My child feels nervous around certain peers.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

21. My child feels shy even with peers he/she knows well.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

22. It's hard for my child to ask others to do things with him/her.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time