



Fetal Alcohol Spectrum Disorders Clinic Parent Questionnaire

| | | |
|-------------------------|-----------------------------|---------|
| Child's Name: | Date of birth: | Gender: |
| Your name: | Your relationship to child: | |
| Telephone (home): | Telephone (work): | |
| Telephone (cell): | Email address: | |
| Address: | | |
| Name of Child's Doctor: | | |
| Telephone: | Fax: | |
| Address: | | |

Caseworker (if applicable): _____ Telephone: _____

Who suggested you come for this evaluation?

CHIEF COMPLAINT: *What is your greatest concern about your child for which you would like help?*

HISTORY OF PRESENTING ILLNESS: *When did the problem begin? What have you tried to make it better?*

What do you hope to gain from the evaluation?

TRAUMA HISTORY: *Has your child experienced trauma in his/her life? Check yes/no for each.*

| Has your child experienced... | Yes | No |
|---|-----|----|
| Has your child ever been in or seen a serious accident where someone could have been, or was severely injured or died? | | |
| Has your child ever been in a serious natural disaster where someone could have, or was severely injured or died? | | |
| Has your child ever experienced the severe illness or injury of someone close to him/her? | | |
| Has your child ever experienced the death of someone close to him/her? | | |
| Has your child ever undergone any serious medical procedures or had a life threatening illness? Or been treated by a paramedic, seen in an emergency room, or hospitalized overnight for a medical procedure? | | |
| Has your child ever been separated from you or another person who your child depends on for love or security for more than a few days OR under very stressful circumstances? (Foster care, immigration, war, major illness, or hospitalization) | | |
| Has someone close to your child ever attempted suicide or harmed him or herself? | | |
| Has someone ever physically assaulted your child, like hitting, pushing, choking, shaking, biting, or burning? Or punished your child and caused physical injury or bruises. Or attacked your child with a gun, knife, or other weapon? (This could be done by someone in the family or by someone not in your child's family). | | |
| Has someone ever directly threatened your child with serious physical harm? | | |
| Has someone ever mugged or tried to steal from your child? Or has your child been present when a family member, other caregiver, or friend was mugged? | | |
| Has anyone ever kidnapped your child? (including a parent or relative) Or has anyone ever kidnapped someone close to your child? | | |
| Has your child ever been attacked by a dog or other animal? | | |
| Has your child ever seen, heard, or heard about people in your family physically fighting, hitting, slapping, kicking, or pushing each other? Or shooting with a gun or stabbing, or using any other kind of dangerous weapon? | | |
| Has your child ever seen or heard people in your family threaten to seriously harm each other? | | |
| Has your child ever known or seen that a family member was arrested, jailed, imprisoned, or taken away (like by police, soldiers, or other authorities)? | | |
| Has your child ever seen or heard people outside your family fighting, hitting, pushing, or attacking each other? Or seen or heard about violence such as beatings, shootings, or muggings that occurred in settings that are important to your child, such as school, your neighborhood, or the neighborhood of someone important to your child? | | |
| Has your child ever been directly exposed to war, armed conflict, or terrorism? | | |
| Has your child ever seen or heard acts of war or terrorism on the television or radio? | | |
| Has someone ever made your child see or do something sexual (like touching in a sexual way, exposing self or masturbating in front of the child, engaging in sexual intercourse)? | | |
| Has your child ever been present when someone was being forced to engage in any sort of sexual activity? | | |
| Has your child ever repeatedly been told s/he was no good, yelled at in a scary way, or had someone threaten to abandon, leave or send him/her away? | | |
| Has your child ever gone through a period when s/he lacked appropriate care (like not having enough to eat or drink, lacking shelter, being left alone when s/he was too young to care for herself/himself, or being left with a caregiver who was abusing drugs)? | | |
| Have there been other stressful things that have happened to your child? | | |

TESI SCORE:

PLACEMENT HISTORY:

How old was your child when you received them into your home? _____

Describe your relationship to your child:

☐ Biological parent ☐ Legal guardian ☐ Foster parent ☐ Adoptive parent ☐ Other: _____

Has your child ever been in foster care? ☐ NO ☐ YES: # of placements: _____

| Caregiver/Placement | Age of Child/duration of placement | Reason for placement change |
|---------------------|------------------------------------|-----------------------------|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

PREVIOUS EVALUTIONS: *Please indicate any evaluations your child has received. Check all that apply.*

| | Results of evaluation if known |
|--|--------------------------------|
| <input type="checkbox"/> Early On/Early Intervention | |
| <input type="checkbox"/> Speech/Language Therapy | |
| <input type="checkbox"/> Physical Therapy | |
| <input type="checkbox"/> Occupational Therapy | |
| <input type="checkbox"/> Behavioral Therapy/Counseling | |
| <input type="checkbox"/> IQ or Psychological Testing | |
| <input type="checkbox"/> Genetics | |

PSYCHIATRIC HISTORY:

Has your child ever been evaluated by a psychiatrist, psychologist, or mental health counselor?

- ☐ NO
☐ YES, *please indicate the psychiatric diagnoses given at the time.*

Has your child ever been **hospitalized** for psychiatric reasons?

- ☐ NO
☐ YES, *please indicate the reason for the hospitalization, location and child's age at the time.*

Has your child ever received **medication** for psychiatric reasons?

- ☐ NO
☐ YES, *please indicate the medication, reason/diagnosis and child's age at the time.*

EDUCATION HISTORY:

| | |
|-----------------|--------|
| Child's School: | Grade: |
|-----------------|--------|

Does your child have an IEP: ☐ NO ☐ YES; Qualification for IEP: _____

Services on IEP:

| | Frequency of Services |
|---|-----------------------|
| <input type="checkbox"/> ECDD Classroom | |
| <input type="checkbox"/> Speech/Language Therapy | |
| <input type="checkbox"/> Physical Therapy | |
| <input type="checkbox"/> Occupational Therapy | |
| <input type="checkbox"/> Social Work / Behavioral support | |
| <input type="checkbox"/> Resource Room | |
| <input type="checkbox"/> OTHER | |

PAST MEDICAL HISTORY:**Pregnancy History (if known):**

Prenatal care began in trimester: ☐ 1 ☐ 2 ☐ 3 ☐ No prenatal care

This was pregnancy # _____ Total pregnancies _____ Living children _____

Pregnancy was complicated by the following: *Check all that apply.*

- | | |
|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Maternal depression | <input type="checkbox"/> Intimate partner violence |
| <input type="checkbox"/> Tobacco use: _____ cigarettes/day | <input type="checkbox"/> Substance use: _____ |
| <input type="checkbox"/> Preterm labor: _____ weeks | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> NONE | |

PRENATAL ALCOHOL USE: *It is critical that we have reliable information about the mother's use of alcohol during pregnancy; information about alcohol use prior to pregnancy is also helpful, if known. Although anecdotal information is helpful, the patient might not receive an alcohol-related diagnosis if alcohol history is unconfirmed. Provide what you can; casework records are often a source for this information, and we urge parents to find verifiable information if at all possible.*

| | Beer How much? How often? | Wine How much? How often? | Liquor How much? How often? |
|---|------------------------------|------------------------------|--------------------------------|
| BEFORE pregnancy | | | |
| DURING pregnancy <input type="checkbox"/> 1 st Trimester | | | |
| <input type="checkbox"/> 2 nd Trimester | | | |
| <input type="checkbox"/> 3 rd Trimester | | | |

Has the mother had any of the following alcohol related risk factors before or during pregnancy:

| | Yes | No | Unknown |
|--|-----|----|---------|
| ≥ 6 drinks / week for ≥ 2 weeks during pregnancy | | | |
| ≥ 3 drinks per occasion on ≥ 2 occasions during pregnancy | | | |
| Documentation of alcohol-related social or legal problems in proximity to (before or during) the index pregnancy (e.g. history of DUI or treatment of an alcohol related disorder) | | | |
| Documentation of intoxication during pregnancy by blood, breath, or urine alcohol content testing | | | |
| Positive testing with an established alcohol-exposure biomarker during pregnancy or at birth | | | |
| Increased prenatal risk associated with drinking during pregnancy identified on a screening test (e.g. TACER; AUDIT) | | | |

Was the mother ever in treatment for **alcohol abuse**?

☐ NO ☐ YES, when: _____ where: _____

Was the mother ever in treatment for **substance abuse**?

☐ NO ☐ YES, when: _____ where: _____

Medications taken during pregnancy: *Check all that apply.*

☐ Prenatal vitamins ☐ Folic acid ☐ Other: _____

BIRTH HISTORY *(if known):*

Birth Hospital: _____ City, State: _____

Name at birth (if different from current name): _____

Gestational Age: _____

Birth weight: _____ Birth length: _____ Head circumference: _____

Delivery: ☐ Vaginal ☐ C-section

Neonatal history was notable for the following: *Describe any complications during/after birth.*

GROWTH HISTORY: *Has your child ever demonstrated poor growth/weight gain?*

☐ No problems with growth or weight gain (growth/weight gain have been normal)

☐ History of **POOR WEIGHT GAIN** (weight < 10%) When: _____

☐ History of **POOR GROWTH** (height < 10%) When: _____

CURRENT MEDICAL PROBLEMS:

Surgeries:

Hospitalizations:

Allergies:

Current Medications:

REVIEW OF SYSTEMS: *Does your child have any of the following? Check all that apply.*

| System | Description |
|---|-------------|
| <input type="checkbox"/> Breathing problems | |
| <input type="checkbox"/> Heart/circulation problems | |
| <input type="checkbox"/> Neurological problems (e.g. seizures, headaches) | |
| <input type="checkbox"/> Feeding/growth problems | |
| <input type="checkbox"/> Problems with blood (e.g. anemia, leukemia) | |
| <input type="checkbox"/> Chronic infections | |
| <input type="checkbox"/> Problems with kidneys | |
| <input type="checkbox"/> Musculoskeletal problems | |
| <input type="checkbox"/> Vision problems | |
| <input type="checkbox"/> Hearing problems | |
| <input type="checkbox"/> Endocrine problems | |
| <input type="checkbox"/> Urological problems | |
| <input type="checkbox"/> Sleep problems | |
| <input type="checkbox"/> Elimination problems | |
| <input type="checkbox"/> OTHER | |

BIOLOGICAL FAMILY HISTORY: *Family history is notable for the following. Check all that apply.*

| Family History of | Person(s) Affected |
|---|--------------------|
| <input type="checkbox"/> ADHD | |
| <input type="checkbox"/> Autism | |
| <input type="checkbox"/> Developmental delay | |
| <input type="checkbox"/> Learning disability/repeated grade in school | |
| <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Other mental illness: _____ | |
| <input type="checkbox"/> Alcohol abuse | |
| <input type="checkbox"/> Substance abuse | |
| <input type="checkbox"/> Incarceration | |
| <input type="checkbox"/> OTHER: _____ | |

SOCIAL HISTORY: *Who lives at home? Check all that apply.*

| Relationship | Age | Job/Occupation |
|--------------------------|-----|----------------|
| <input type="checkbox"/> | | |
| <input type="checkbox"/> | | |
| <input type="checkbox"/> | | |
| <input type="checkbox"/> | | |
| <input type="checkbox"/> | | |
| <input type="checkbox"/> | | |
| <input type="checkbox"/> | | |
| <input type="checkbox"/> | | |
| <input type="checkbox"/> | | |
| <input type="checkbox"/> | | |

Stressors: *Please indicate if your child has experienced any of the following. Check all that apply.*

- ☐ Domestic violence
- ☐ Child physical abuse
- ☐ Sexual abuse
- ☐ Neglect
- ☐ CPS involvement
- ☐ Foster care
- ☐ Institutionalization
- ☐ Financial concerns
- ☐ OTHER: _____

OTHER QUESTIONS OR CONCERNS: