Structured Clinical Interview for Parents

This questionnaire helps us gather information about your child and family that will be helpful in determining the type of treatment which would be most likely to help with the problems your child is experiencing. Please fill out all of the questions as completely as possible.

I. IDENTIFYING INFORMATION

Child's name ____
Last First Middle

Address ____
Street City State ZIP

Date of birth ____/____/____ Current age ___________

Ethnicity: White Hispanic African American Asian Other

Grade _________ School ______________________ District _____________

Legal guardian bringing child for treatment ______________________

Relationship to child ______________________________

II. PARENTS (If parents are separated, please circle parent child lives with most of the time.)

Mother ______________________ Home phone: ________ Work phone: ________

Father ______________________ Home phone: ________ Work phone: ________

(cont.)

From *Treating ADHD and Comorbid Disorders: Psychosocial and Psychopharmacological Interventions* by Steven R. Pliszka. Copyright 2009 by The Guilford Press. Permission to photocopy this appendix is granted to purchasers of this book for personal use only (see copyright page for details.)

III. MARITAL HISTORY

	Date of marriage	Date divorced/ widowed (if applicable)	Name of stepparent
Child's biological/adoptive parents	______	______	______
Mother's 2nd marriage	______	______	______
Father's 2nd marriage	______	______	______
Mother's 3rd marriage	______	______	______
Father's 3rd marriage	______	______	______

If parents are separated, does the noncustodial parent want to be involved in the treatment of the child? Yes No

If yes: Do you think the noncustodial parent will object to medication or counseling for your child? Yes No

Mother's/stepmother's educational level:	Father's/stepfather's educational level:
1. Less than 7th grade	1. Less than 7th grade
2. 8–9th grade	2. 8–9th grade
3. 10–11th grade	3. 10–11th grade
4. High school graduate	4. High school graduate
5. Partial college (at least 1 year)	5. Partial college (at least 1 year)
6. Standard college degree (i.e., 4 years)	6. Standard college degree (i.e., 4 years)
7. Graduate degree beyond college	7. Graduate degree beyond college
Current occupation ______	Current occupation ______

IV. BROTHERS AND SISTERS OR OTHER FAMILY MEMBERS IN CHILD'S MAIN RESIDENCE

1. ______ Age (   )
2. ______ Age (   )
3. ______ Age (   )
4. ______ Age (   )
5. ______ Age (   )
6. ______ Age (   )
7. ______ Age (   )

(cont.)

V. CHILD'S PROBLEMS

Please briefly describe your child's problems. ______________________________

____

____

____

____

____

____

____

____

____

____

____

VI. CHILD'S HEALTH HISTORY

A. Mental Health Treatment

Please list any medications your child is on now or has been on in the past for behavioral or emotional problems.

Medicine	Doctor	Dates taken	Results		
			Good	Fair	Poor
			Good	Fair	Poor
			Good	Fair	Poor
			Good	Fair	Poor

Has your child been in therapy or counseling before? Yes No

Therapist/clinic	When?	No. of times seen	Results		
			Good	Fair	Poor
			Good	Fair	Poor
			Good	Fair	Poor

Has your child been in a psychiatric (mental) hospital before? Yes No

Hospital	When?	Doctor	Results		
			Good	Fair	Poor
			Good	Fair	Poor
			Good	Fair	Poor

(cont.)

B. Medical History

Please list any serious illness, operations, or hospitalizations.

Child's age when ill   Type of illness/injury   Treatment

____

____

____

____

____

____

____

C. Difficulties during Pregnancy or Childbirth

Did you have any difficulties during your pregnancy or during your child's birth? If yes, please describe.

____

____

____

VII. DEVELOPMENT

At what age did your child:

Hold his/her head up ________   Smile ________   Sit up ________

Take first steps ________   Walk ________   Run ________

Babble, coo ________   Say first words ________   Use sentences ________

Toilet trained ________   Was toilet training easy/hard? ________

Slept through the night ________   Was he/she a "fussy" or "easy" baby? ________

Did he/she suffer from colic? If yes, please describe. ____________________

____

As an infant or toddler did your child have trouble attaching or bonding to either parent? If yes, please describe. ____________________

____

____

Did (or does) he/she have any speech delays or problems? ____________________

____

____

Does he/she have problems with poor motor coordination (being clumsy)? ____________________

If yes, please describe: ____________________

____

(cont.)

Does your child have a main best friend?	Yes	No
Does your child have a steady group of friends?	Yes	No
Does your child have trouble making friends?	Yes	No
Does he/she have trouble keeping friends?	Yes	No
Does your child have friends who get him/her in trouble?	Yes	No
Is he/she a leader or a follower?	Yes	No
Do neighbors tell their children not to interact with your child?	Yes	No
Do other children think your child is "weird" or "odd"?	Yes	No
Do other children think your child is mean?	Yes	No
Does he/she play mostly with younger children?	Yes	No
Do teachers or day-care workers say your child doesn't get along with other children?	Yes	No

VIII. CHILD'S SCHOOLING

Please list the schools your child has attended since kindergarten.

Grade school		Teacher reported behavior or learning problems?	In special education?
K.	________________	Yes No	Yes No
1.	________________	Yes No	Yes No
2.	________________	Yes No	Yes No
3.	________________	Yes No	Yes No
4.	________________	Yes No	Yes No
5.	________________	Yes No	Yes No
6.	________________	Yes No	Yes No
7.	________________	Yes No	Yes No
8.	________________	Yes No	Yes No
9.	________________	Yes No	Yes No
10.	________________	Yes No	Yes No
11.	________________	Yes No	Yes No
12.	________________	Yes No	Yes No

IX. CHILD'S ACTIVITIES

Bedtime on school days ________ Weekends/holidays ________ Sleeps by self? ________

Typical bedtime behavior: Goes to bed easily Argues/resists Scared/needs reassurance

Wets bed? Yes No Nightmares? Yes No

Sleepwalking? Yes No Loud snoring? Yes No

(cont.)

Wake-up time on school days ________ Wake-up time on weekends ________

Hours of sleep/night ______________

Average hours of television watched on school nights ________ Weekends ________

What sports is the child involved in? ____

____

____

What other structured activities (scouts, church, etc.) is the child involved in? __________________

____

____

Describe the child's computer/Internet usage. ____

____

____

____

Child and Adolescent Clinician Interview

Child's name ______________________ Age ______ Date of interview ____/____/______

Examiner ________________________________ Date of birth ____/____/____

Informant ________________________

Instructions

1. Have parent fill out rating scales:
   a. ADHD Rating Scales (parent/teacher)
   b. Child Mania Rating Scale Questionnaire
   c. Aggression Questionnaire
2. Interview parent alone first, without the child. Review rating scales, assess details of problems. If developmental problems endorsed, administer screening scales for autism spectrum diorder.
3. Interview child alone. Obtain the following rating scales from child (> 7 years):
   a. Depression Scale
   b. Anxiety Scale
   c. CRAFFT
4. Integrate data and debrief parent.

Chief complaint ____

Brief overview of history ____

____

____

____

____

____

Obtain medical and developmental milestones from New Patient Questionnaire.

(cont.)

From *Treating ADHD and Comorbid Disorders: Psychosocial and Psychopharmacological Interventions* by Steven R. Pliszka. Copyright 2009 by The Guilford Press. Permission to photocopy this appendix is granted to purchasers of this book for personal use only (see copyright page for details.)

I. DISRUPTIVE BEHAVIOR DISORDERS

Attention-Deficit/Hyperactivity Disorder (ADHD)

Parent Rating Scale

Inattention ________ of 9 symptoms rated > 1

Impulsivity/hyperactivity ________ of 9 symptoms rated > 1

Age of onset ________ Yes No Present nearly every day > 6 months

Teacher Rating Scale

Inattention ________ of 9 symptoms rated > 1

Impulsivity/hyperactivity ________ of 9 symptoms rated > 1

________ Teacher rating not available

Oppositional Defiant/Conduct Disorder (ODD/CD)

Parent Rating Scale

Oppositional defiant ________ of items 9 rated > 1

Conduct disorder ________ of items 13 rated > 1

Teacher Rating Scale

Oppositional defiant ________ of items 19–22 rated > 1

Conduct disorder ________ of items 23–28 rated > 1

________ Teacher rating not available

Yes No Parent history reliable Yes No Parent provides examples of behavior

Yes No Clinical judgment confirms diagnosis. If no, please document why not below.

If aggressive behavior is present, have parent fill out Aggression Questionnaire.

____

____

II. MOOD DISORDERS

Review Child Mania Rating Scale, Mood and Feelings Questionnaire, and Anxiety Scales. Discuss with parent and assess as below.

Mood state during current episode of illness	Euthymic Depressed Euphoric Irritable Mixed	Does your child have times when he/she is sad? How about irritable, grouchy, or miserable all the time? Does your child have times when he/she is so happy you think something is wrong with him/her? How about extremely silly or giddy?
Severity of mood disturbance	Mild Moderate Severe	

(cont.)

<table>
<tr><td>How long do the moods last?</td><td>Minutes
Hours
All day</td><td rowspan="3">How often does this happen?
When these episodes occur, how long do they last? Do they keep him/her from doing activities or meeting responsibilities?
How long have these things been going on?
If child is irritable: Is he/she only irritable when he/she is being punished or can't have his/her way?</td></tr>
<tr><td>How often do the moods occur?</td><td>Once a month
Once a week
3–5 times/week
Daily</td></tr>
<tr><td>How long has the current episode lasted? Fill in one:</td><td>________ days
________ weeks
________ months
________ chronic;
age of onset ________</td></tr>
</table>

Associated Symptoms of Major Depression			
Pleasure loss	Yes No	Excessive pessimism	Yes No
Appetite loss	Yes No	Psychomotor agitation	Yes No
Appetite increase	Yes No	Psychomotor retardation	Yes No
Weight loss	Yes No	Energy loss/fatigue	Yes No
Weight gain	Yes No	Low self-esteem	Yes No
Trouble falling asleep	Yes No Bedtime: Falls asleep:	Poor concentration (If child has ADHD, does sadness impair concentration over baseline?)	Yes No
Awakening during night	Yes No	Abnormal guilt	Yes No
Early morning awakening	Yes No Wake-up time:	Circadian rhythm reversal	Yes No

Associated Symptoms of Mania			
Increased energy	Yes No	Grandiosity	Yes No
Distractibility	Yes No	Sexual interest	Yes No
Hypertalkative	Yes No	Decreased need for sleep Hours of sleep per night	Yes No
Pressured speech/ push of speech	Yes No	Delusions of grandeur/paranoia	Yes No
Intrusiveness	Yes No	Flight of ideas	Yes No

(cont.)

Current suicidal ideation? No Yes

Current suicidal plan? No Yes

Current suicidal intent? No Yes

If Yes, describe current suicidal ideation. ____

____

____

Past suicide attempts/gestures: None

Date	Age at time	Method	Outcome

Past Episodes of Depression or Mania

______ The current episode is the first and only episode in the child's life (present 1 year or less).

______ The abnormal mood state has been chronic (more than a year) and appeared to begin when the child was age ________.

______ The mood state has been getting progressively worse and is now the worst it has ever been.

______ The mood state has been getting better and was at its worst when the child was age ________.

______ The child has had several discrete abnormal mood states separated by periods when he/she was doing well.

Type of episode	Age at episode	Approximate length
Depression/mania/anger/mixed		
Depression/mania/anger/mixed		
Depression/mania/anger/mixed		
Depression/mania/anger/mixed		

(cont.)

III. ANXIETY DISORDERS

Generalized Anxiety Disorder	Yes No	Is the anxiety associated with:	Frequency	< once/month Monthly 1–3 times/month Weekly Daily
Worries excessively about schoolwork	Yes No	Restlessness Yes No		
Blames self for things that are not his/her fault	Yes No	Tiredness Yes No		
Worries excessively about how he/she does at sports/games	Yes No	Poor concentration Yes No	How long?	Minutes Several hours All day
Worries excessively about bad things happening in the world	Yes No	Irritability Yes No	Duration	1–3 weeks 1 month 2–6 months > 6 months
Worries excessively about upcoming events	Yes No	Muscle tension Yes No		
Worries excessively about getting sick or dying	Yes No	Sleeplessness Yes No	When did current episode begin?	
Very scared of meeting new people or social situations	Yes No			

No trauma/PTSD reported ________

Has the child suffered a severe trauma? If Yes, ask about posttraumatic stress disorder.	
Recurrent and intrusive recollections of the event and/or repetitive play with theme of trauma	
Recurrent, distressing dreams of the event	
Acting or feeling as if the traumatic event were recurring (i.e., flashbacks)	
Intense distress when exposed to reminders of the trauma	

No separation probems reported ________

Does the child have separation difficulties? If yes, ask about separation anxiety.	
Extremely upset when separated	
Excessive worry about losing or harm befalling loved one	
Excessive worry about an event which will lead to separation	
Refusal to go to school or elsewhere because of fear of separation	

Physiological reactivity when exposed to reminders of the event	
Posttraumatic stress disorder—Avoidance	
Efforts to avoid thoughts, feelings, conversations about the trauma	
Efforts to avoid activities or places associated with the trauma	
Lack of recall of all or part of the trauma	
Decreased interest in activities	
Detachment or estrangement from others	
Restricted range of affect	
Sense of foreshortened future	
Posttraumatic stress disorder—Physiological	
Difficulty falling asleep	
Irritability or outburst of anger	
Difficulty concentrating	
Hypervigilance	
Exaggerated startle response	

Refusal to be alone without attachment figures nearby	
Refusal to go to sleep without attachment figures in room or nearby	
Frequent nightmares with theme of separation	
Repeated complaints of physical complaints when separation occurs	
Is duration of symptoms at least 4 weeks?	

No OCD-like symptoms reported ________

Does the child have rituals/compulsions? If yes, ask about OCD.	
Fears of becoming aggressive toward others	
Unwanted guilt-ridden sexual thoughts	
Religious obsessions	
Obsessions of germs/disease	
Obsessions of cleanliness, dirt	
Obsessions about being on time, being late	
Obsessions about following rules	
Hand washing	
Checking locks, ovens, etc.	
Arranging objects in certain ways	

No panic symptoms reported ________

Does the child have severe panic (anxiety) attacks? If yes, ask about panic attacks.	
Palpitations, pounding heart	
Sweating	
Trembling or shaking	
Sensations of shortness of breath (SOB) or smothering	
Feelings of choking	
Chest pain or discomfort	
Nausea or abdominal distress	
Feeling dizzy, unsteady, faint	
Derealization	
Fear of going crazy	

(cont.)

Obsessively counting objects	
Ritualistic actions	
Compulsive praying	
Saying repetitive words to self	

Fear of dying	
Paresthesias	
Chills or hot flushes	
Agoraphobia	

Does the child have tics? No/Yes If yes, list: ______________________________

____

IV. SUBSTANCE ABUSE

No substance abuse reported _______

Substance	Ever in life	Last time of use	Frequency and pattern of use
Alcohol			
Marijuana			
Stimulants, speed			
Cocaine			
Opiates			
Hallucinogens			
Other			

V. DEVELOPMENT/AUTISM SPECTRUM DISORDERS

Review infancy and early childhood milestones.

Note any developmental delays from chart or parent questionnaire.

____

____

____

Note: Items below are for screening. If concern is elicited, more intensive evaluation is required.

Autistic/PDD behaviors _______ No autistic behaviors reported	
Poor eye contact	
Lack of language development	

Asperger's behaviors (language must be present) _______None	
Flat tone of voice all the time	
Tone of voice doesn't match emotion	

(cont.)

Language random, not used to communicate		Very wordy, uses words that are odd	
Makes meaningless sounds		Talks excessively and annoyingly about one interest	
Obsessions with objects		Usually good memory for facts	
Obsessions with sameness		Peers think he/she is “weird”	
Toe walking or hand flapping		Doesn’t see what others are feeling	
Repeats what is said (echolalia)		Doesn’t realize when he/she hurts others’ feelings	
Does not use pronouns (I, you, me)		Can’t figure out why others are mad	
Does not have social bond with parents/ siblings		Always does the “wrong” thing at social gatherings	
Does not have social bond with others, ignores people		Clumsy, poor motor skills	
Ritualistic actions		Doesn’t like to be touched, hugged	
Pica, eats odd objects		No good at make-believe (for younger child)	
Other odd behaviors or movements		Doesn’t understand jokes or tells meaningless jokes	

Psychosis screen	Full assessment	Parent
Hears voices Yes No	Talks to people who are not there, talks to self abnormally	Yes No
	Literally believes he/she is someone else	Yes No
Sees things Yes No	Claims to hear voices talking to him/her	Yes No
	Claims his/her mind is being controlled by others	Yes No
Paranoid Yes No	Claims to get messages from TV/radio	Yes No
	Believes important people(e.g., the president) know him/her	Yes No
Talks to self Yes No	Involved in “Satan worship” or strange religious activities	Yes No
	Paranoid, thinks people are plotting to get him/her	Yes No
Abnormal speech Yes No	Has developed strange or bizarre ideas about the world	Yes No
If Yes to any of the above, ask detailed questions at right.	Claims to have visions or see things no one else can	Yes No
	Speech makes no sense at all	Yes No
	Very strange or bizarre fanatasy life, inappropriate for age	Yes No

(cont.)

VI. FAMILY HISTORY

	Father	Mother	Sibs	Pat. GM	Pat. GF	Pat. Uncle	Pat. Aunt	Pat. Cousin	Mat. GM	Mat. GF	Mat. Uncle	Mat. Aunt	Mat. Cousin
Depression													
ADHD													
Alcoholism													
Drug abuse													
Criminal behavior/history													
Schizophrenia													
Mania													
OCD													
Tics													
Anxiety													

VII. PAST PSYCHIATRIC HISTORY

Psychotropic Medication: None

Medication	Indication	Dose/ directions	Start date	Stop date	Side effects?	Effective?

Psychiatric hospitalization: None

Hospital	Nature of problem	Date of hosp.	Outcome

(cont.)

CHILD INTERVIEW

I. Open-ended interview. Establish rapport (5 minutes). Review ADHD, ODD, CD, and aggression items from parent interview.

II. Administer Mood and Feelings/Anxiety Questionnaire. Discuss items endorsed as positive by child.

Depression/Anxiety Self-Ratings: Completed Not done/Invalid

Current suicidal ideation? No Yes In past

Current suicidal plan? No Yes In past

Current suicidal intent? No Yes In past

If yes or in past to any of the above, describe. ____

____

III. Substance abuse (> age 10 years). Administer CRAFFT.

No substance abuse reported _______

Substance	Ever in life	Last time of use	Frequency and pattern of use
Alcohol			
Marijuana			
Stimulants, speed			
Cocaine			
Opiates			
Hallucinogens			
Other			

CRAFFT (for those who endorse any use)

Have you ever ridden in a CAR driven by someone (including yourself) who was high or had been using alcohol or drugs? Yes No

Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? Yes No

Do you ever use alcohol or drugs while you are by yourself, ALONE? Yes No

Do you ever FORGET things you did while using alcohol or drugs? Yes No

Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use? Yes No

Have you ever gotten into TROUBLE while you were using alcohol or drugs? Yes No

(cont.)

CHILD AND ADOLESCENT MENTAL STATUS EXAMINATION

I. Appearance

Maturity: ____ appropriate ____ immature ____ overly/pseudo mature
Dress: ____ appropriate ____ unkempt ____ provocative ____ meticulous
Speech: ____ articulate ____ poorly articulated
Speech rate: ____ appropriate ____ slowed ____ rapid
Activity: ____ appropriate ____ decreased ____ increased

II. Mood and Affect

Depression: ____ none ____ mild ____ moderate ____ severe
Elation: ____ none ____ mild ____ moderate ____ severe
Irritability ____ none ____ mild ____ moderate ____ severe
Affect: ____ appropriate ____ blunted ____ flat ____ labile____ intense

III. Orientation

Person: ____ yes ____ no
Place: ____ yes ____ no ____ not applicable for age
Time: ____ yes ____ no ____ not applicable for age

IV. Intelligence

____ below average ____ average ____ above average
Basis of estimate: ____ prior testing ____ vocabulary

V. Thought Processes/Cognition

Loose associations: ____ present ____ absent ____ unsure/no inquiry
Auditory hallucinations: ____ present ____ absent ____ unsure/no inquiry
Visual hallucinations: ____ present ____ absent ____ unsure/no inquiry
Paranoia: ____ present ____ absent ____ unsure/no inquiry
Ideas of reference: ____ present ____ absent ____ unsure/no inquiry
Delusions (grandiose): ____ present ____ absent ____ unsure/no inquiry
Delusions (persecution): ____ present ____ absent ____ unsure/no inquiry
Intrusive thoughts: ____ present ____ absent ____ unsure/no inquiry
Thoughts incoherent: ____ yes ____ no

VI. Suicidal Ideation

____ none ____ suicidal plan, no intent to carry out
____ wishes he/she were dead ____ clear intent to harm/kill self
____ suicidal thoughts, no plan

VII. Homicidal Ideation

____ none
____ thoughts of harming others, no threats
____ general threats to harm others
____ plan to harm specific individuals

(cont.)

DIAGNOSES

Axis I ________________________ ________________________ ________________________

Axis II ________________________ ________________________ ________________________

Axis III ________________________ ________________________ ________________________

Axis IV (Psychosocial Stressors) ____

Axis V (GAF) ____________________

Impression/formulation: ____

____

____

____

____

Risks/benefits/side effects of medications discussed as follows: ______________________

____

Medication	Dosage	No. of pills	Refills

Treatment plan: ____

____

____

____

____

____

____ Referral for psychotherapy

____ School consultation

____
Clinician signature

____
Clinician printed name