Behavioral Pediatric & Family Therapy Program
Child Family Inventory

PATIENT INFORMATION

Patient Name: _____ Nickname: _____

Age: _____ Birth date: _____ Gender: _____

Address: _____ Phone: _____

Parent / Legal Guardian Name: _____ Age: _____

Relationship to Patient (circle one):

Biological Adoptive Foster Step Married: _____ Divorced: _____
Date Date

Parent / Legal Guardian Name: _____ Age: _____

Relationship to Patient (circle one):

Biological Adoptive Foster Step Married: _____ Divorced: _____
Date Date

Name of Other Member(s) of the Household:	Age	Gender	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who Referred You? _____ Patient's Physician: _____

Reason for Referral? _____

_____

PATIENT ASSESSMENT

Complications with fertility, pregnancy, labor/delivery: _____

_____

Growth and Development:

General impression of infant development: (circle one) Poor Fair Good

Note the month patient achieved the following activities:

Sat Alone _____ Crawled _____ Walked _____ Feed Self _____ Spoke Words _____
(Typical: Sit, 6-8 mo.; Crawl, 9 mo.; Walk, 12-18 mo.; Feed, 10-12 mo.; Speak, 10 mo.)

General Appearance: _____

Weight: _____ Height: _____

Physical Assessment of Vision, Hearing, and Speech:

Vision: Normal Abnormal Corrected

Hearing: Normal Abnormal Corrected

Speech: Normal Abnormal Corrected

Does patient have a physical health problem which interferes with normal functioning? Yes No

If yes, describe: _____

_____

Has patient had any genetic or medical testing done in the past? Yes No

If yes, what type of testing and by whom? _____

_____

Is patient on any medications at the present time? Yes No

For what is it prescribed? _____ How long has patient been on it? _____

Name of medicine and who prescribed it? _____

Does the medication affect patient's behavior? Yes No How? _____

_____

Emotional Status:

Does patient have a behavioral or emotional problem that concerns you? Yes No

If yes, describe: _____

_____

Has patient ever received counseling or psychotherapy? Yes No

If yes, describe reasons for counseling / psychotherapy, therapist name(s), and date(s):

_____

_____

Is the relationship good between patient and parent(s) / guardian(s)? Yes No

If no, elaborate: _____

Is the relationship good between patient and other household members? Yes No

If no, elaborate: _____

Which of the following have been or are now problems with patient?

	Yes	No	Sometimes		Yes	No	Sometimes
Won't Mind	_____	_____	_____	Soiling	_____	_____	_____
Too Active	_____	_____	_____	Bedwetting	_____	_____	_____
Bad Temper	_____	_____	_____	Cries Too Much	_____	_____	_____
High Strung or Nervous	_____	_____	_____	Clings to Parents	_____	_____	_____
Breath holding	_____	_____	_____	Toilet Training	_____	_____	_____
Easily Upset	_____	_____	_____	Lying	_____	_____	_____
Clumsy	_____	_____	_____	Too Shy	_____	_____	_____
Night Terror	_____	_____	_____	Siblings	_____	_____	_____
Destructive	_____	_____	_____	Hyperactive	_____	_____	_____
Head banging	_____	_____	_____	Other	_____	_____	_____

When did you first notice concerns? _____

SCHOOL ASSESSMENT

Patient school: _____ City/State: _____ Grade: _____

Teacher Name: _____ Principal Name: _____

Hours in attendance: _____

Is patient home-schooled? Yes No

Hours in attendance: _____

Describe school progress (circle one) Poor Fair Good Very Good

According to the teacher, patient:	Yes	No	Sometimes	Date of Onset
Has difficulty following instructions	_____	_____	_____	_____
Speech / Language concerns	_____	_____	_____	_____
Completing assignments	_____	_____	_____	_____
Talks out of turn	_____	_____	_____	_____
Learning difficulties	_____	_____	_____	_____
Has a short attention span	_____	_____	_____	_____
Has trouble finishing work	_____	_____	_____	_____
Does not get along with other children	_____	_____	_____	_____
Has poor school attendance	_____	_____	_____	_____

Have you had special or extra conferences with teacher or school authorities for behavior or learning problems? Yes No

Does patient receive any Special Education Services? Yes No

Has patient ever been tested for learning, behavior, or speech problems? Yes No

Does patient have an IEP / 504 Plan? Yes No

What do they suggest is needed to help patient? _____

_____

Do you agree with teacher, or what are your ideas about what is needed? _____

_____

Is patient involved in extracurricular activities? Yes No

If yes, describe: _____

FAMILY ASSESSMENT

Parent / Guardian Name: _____ Education: _____

Employer / Job Position: _____ Work hours: _____

Describe overtime work or second job: _____

Home schedule: _____

_____

Parent / Guardian Name: _____ Education: _____

Employer / Job Position: _____ Work hours: _____

Describe overtime work or second job: _____

Home schedule: _____

_____

Do you think the family is under financial strain? Yes No

Are you receiving any type of financial assistance? Yes No

Describe past or recent stressors: _____

Describe past or recent legal issues: _____

Describe any neglect / trauma history: _____

Describe a typical day experienced by your family: _____

_____

_____

Has either parent / guardian received medication, counseling, or psychotherapy? Yes No

If yes, describe the issues and diagnoses: _____

_____

Therapist name(s) and date(s): _____

_____

How would you describe your marriage / relationship during the past six months? (circle one)

Very Good Good Fair Bad Very Bad N/A

How would you describe your marriage / relationship during the last month? (circle one)

Very Good Good Fair Bad Very Bad N/A

Does either parent / guardian have a physical health problem that interferes with normal functioning?

Yes No If yes, please describe: _____

_____

CHILD MANAGEMENT

Who ordinarily disciplines patient? _____

How is patient disciplined? Timeout Spank Yell Take Privileges Send to Room Reasoning

Other (describe): _____

How often do you need to use discipline? _____

Have your methods of discipline been effective? Yes No

Do you and patient's other parent / guardian agree on discipline? Yes No

What does patient like to do with you?

Parent / Guardian Name: _____

Preferred activities: _____

Parent / Guardian Name: _____

Preferred activities: _____

SIBLING ASSESSMENT

Emotional status:

Has any sibling received counseling or psychotherapy? Yes No

If yes, describe the issues and diagnoses: _____

_____

Therapist name(s) and date(s): _____

_____

Does any sibling have an emotional or behavioral problem that concerns you? Yes No

If yes, describe: _____

_____

ADOLESCENT ASSESSMENT

(If applicable, please complete the following)

To your knowledge, has your adolescent:

Used alcohol or drugs Yes No

If yes, explain: _____

_____

Had a positive drug screen Yes No

Had a SCIP evaluation Yes No

Used tobacco Yes No

Been sexually active Yes No

Run away from home Yes No

Had legal difficulties Yes No

If yes, please explain (probation officer, court date, etc.): _____

_____

Other concerns not mentioned: _____

Does your adolescent have difficulties with any of the following:

	Often	Occasionally	Seldom	Never
Curfews	_____	_____	_____	_____
Skipping school	_____	_____	_____	_____
Failing grades	_____	_____	_____	_____
Peers	_____	_____	_____	_____
Suicide threats or attempts	_____	_____	_____	_____
Destruction of property	_____	_____	_____	_____
Aggression	_____	_____	_____	_____