The Columbia University Clinic for Anxiety and Related Disorders
Youth Anxiety Center (YAC)

Background Questionnaire

To be filled out by Adolescents (16-17 years old) with Parents

BACKGROUND QUESTIONNAIRE

(To be filled out by parent/main caretaker or patient)

Note: For questions that do not apply to you, please indicate that it is not applicable by witting "N/A" as the answer choice.

Patient's Name*: _____ **Patient's Date of Birth*:** _____

Name of the person filling out the form*: _____

Relation to youth: _____

Email of person filling out form*: _____

Patient's Street Address*: _____
City, State, Zip

_____

Person to contact in case of emergency (All information is kept confidential: person will only be called in the event of an emergency. Please see limits of confidentiality section of the consent for assessment/treatment form for details):
Name: _____ ***Phone Number:*** _____

Family Contact Information

Primary parent #1 Name: _____ **Age:** _____

Gender: _____

Address (if different than patient's): _____

_____

Phone: _____ **Work/Cell Phone:** _____

Email Address:_____

Preferred Method of Contact: __ Phone __ Email __ Both

Relationship to Patient: __ Biological Parent __ Adoptive Parent __ Step Parent __ Other

Primary parent #2 Name: _____ **Age:** _____

Gender: _____

Address (if different than patient's): _____

_____

Phone: _____ **Work/Cell Phone:** _____

Email Address:_____

Preferred Method of Contact: __ Phone __ Email __ Both

Relationship to Patient: __ Biological Parent __ Adoptive Parent __ Step Parent __ Other

Today's date: _____
(mm/dd/yyyy)

Person Filling Out Form (select one):

- ○ Parent/main caretaker
- ○ Patient
- ○ Both

Demographic and Background Information

Round the primary language spoken in the home: English Spanish Other: _____

Other languages spoken in the home: Other: _____

How do you define the patient's ethnicity? _____ Not Latino or Hispanic _____ Latino or Hispanic

If Hispanic or Latino (check one):

_____ Mexican, Mexican American, Chicano
_____ Puerto Rican
_____ Cuban
_____ Dominican
_____ Other Hispanic, Latino, or Spanish origin (for example, print origin: Argentinean, Colombian, Nicaraguan, Salvadorian, Spaniard, etc.): _____

What is the name of the racial group that <u>best</u> describes the patient?

_____ White or Caucasian
_____ Black or African-American
_____ American Indian or Alaska Native
_____ Asian
_____ Native Hawaiian or other Pacific Islander
_____ More than one race; Please specify: _____
_____ Other _____

If the patient's family practices a religion, specify the patient's religion as a child: _____

Does the patient currently identify as religious? _____ Yes _____ No
If YES, <u>what religion</u>? _____

Patient's Marital Status (check one):

____ Single
____ Engaged
____ Married; Date of marriage(s) _____
____ Separated
____ Divorced; If divorced, are you remarried? ____ (Yes/No) If yes, how many times? ____
____ Widowed

If patient is engaged, married, separated, or divorced:
Partner's Age: _____ Partner's Gender: _____

Partner's Education Level: _____ Partner's Occupation: _____

Number of Children: _____

If patient has children of their own, what was the age of the patient when first child was born? _____

Patient's Occupation

Is the patient currently employed: _____ **Yes** _____ **No**
Is the patient currently attending School or College: _____ **Yes** _____ **No**

If YES, attending school or college:

Name current school or college*: _____

Main Office Phone*: _____

Placement: **Private / Parochial / Public / Charter / Boarding / Home studies**

Current Grade:
3rd – 4th – 5th – 6th – 7th – 8th – 9th -- 10th – 11th – 12th – GED – College – Masters – PhD

How many years at current school/college? _____
(**in years**)

Teachers Name*: _____

Does patient currently receive Special Education services? ____ **Yes** ____**No**

If YES, what is his/her service classification? _____

Individualized Education Plan (IEP) ____ **Yes** _____**No**

504 accommodations ____ **Yes** _____**No**

When was the patient's last IEP meeting? _____
(**mm/dd/yyyy**)

If don't remember, select one: Last week / Last Month / 2-6 months ago / > 6 months ago

Has patient ever received Special Education services in the past? ____**Yes** ____**No**

Has patient ever had a 504 or other accommodation? ____ **Yes** ____**No**

Family Composition

List ALL people living in the household:

Name	Relationship to Child	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional significant family members living outside of the home (living or deceased):

Name	Relationship to Child	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parental occupation:

What is primary parent #1's current occupation? _____

What is primary parent #2's current occupation? _____

Parental education:

Please, indicate if parents of patient have completed any of the following educational levels:

	Primary Parent #1		Primary Parent #2	
High School	Yes	No	Yes	No
GED	Yes	No	Yes	No
College	Yes	No	Yes	No
Technical or Trade school	Yes	No	Yes	No
Postgraduate or Professional degree	Yes	No	Yes	No

Relationship between the parents:

How would you describe the relationship between the parents/guardians?

_____

_____

Current marital status of the parents:

(Select only one option)

Primary Parent #1		Primary Parent #2	
1. Never married	**4. Separated**	**1. Never married**	**4. Separated**
2. Living Together	**5. Divorced**	**2. Living Together**	**5. Divorced**
3. Married	**6. Widower/widow**	**3. Married**	**6. Widower/widow**

Biological parents ever married to each other?

_____Yes _____ No

If YES, date of marriage: _____

Biological parents ever lived together:

_____ Yes _____ No

If YES, for how long have parents been living together? _____
(in years)

One of the biological parents is no longer living in the household or divorced or separated or deceased:

_____Yes _____ No

If yes, for how long have parents been (separated, divorced, widow/er)? _____
(in years)

If YES, patient's age when parent's relationship ended: _____
(in years)

Who has legal custody in terms of physical and mental healthcare?

Primary Parent #1	Yes	No
Primary Parent #2	Yes	No
Other family member who lives with the patient	Yes	No
An adult who is not a family member but lives with patient	Yes	No

Is the patient legally adopted? _____ No _____ Yes

If YES: Age at adoption: **_____**
(in years)

Is there anyone living in the home with the patient who is a smoker? ____ Yes _____No

If YES, who?

Primary Parent #1	Yes	No
Primary Parent #2	Yes	No
Other family member who lives with the patient	Yes	No
An adult who is not a family member but lives with patient	Yes	No

Brief History of Pregnancy and Infancy

What was the primary parent #1's age at child's conception? _____ (**years)**

What was the primary parent #2's age at child's conception? _____ (**years)**

How many full term pregnancies? _____

Which number is this child (1st, 2nd, 3rd, …)? _____

Did the mother receive prenatal care for this child? _____**Yes** ____ **No**

Length of this child pregnancy: _____ (**in weeks)**

Were there any problems during this child pregnancy? _____**Yes** ____ **No**

If YES, please describe:

_____

_____

During this child pregnancy did you take any of the following? **If YES, which ones?**

Prescription medications	**Yes**	**No**	_____
Over-the-counter drugs	**Yes**	**No**	_____
Vitamins/dietary supplements	**Yes**	**No**	_____

Were cigarettes smoked in the home during this child pregnancy? _____**Yes** ____ **No**

If Yes, how many cigarettes on average per day?
_____ 0-5
_____ 6-10
_____ 11-20
_____ +20

Can you tell us the weight and the length of your child at birth?
Specify the weight: _____ pounds _____kilos _____ Don't remember

Specify length: _____inches _____cm _____ Don't remember

Were there any complications associated with this child delivery? _____**Yes** ____ **No**

If any complications, specify below:

Was this child premature? _____**Yes** ____ **No**

If YES, with how many weeks of pregnancy was he/she born? _____ weeks

Type of delivery: ___ Vaginal ____ C-Section (please describe reason):

_____

Did the child require any special or intensive care post-delivery? ____Yes _____No

If YES, please describe: _____

_____

Was this child born with low weight? _____Yes ____ No

Other complications? _____Yes ____ No

If YES, please describe: _____

_____

Were there any feeding problems? If yes, please describe:

_____

Were there any sleeping problems: If yes, please describe:

_____

As an infant, was your child a difficult baby: ___ yes ___ no

As an infant, did your child like to held: ___ yes ___ no

As an infant, was your child alert: ___ yes ___ no

Developmental Milestones of Child

Please indicate the age (in months) at which your child first demonstrated the following behaviors.

	Months		Months
Crawled	_____	**Babbled**	_____
Stood alone	_____	**Spoke first word**	_____
Walked alone	_____	**Spoke 2-3-word phrase**	_____
Stayed dry at night	_____	**Spoke complete sentence**	_____
Toilet trained	_____	**Fed self**	_____
Dressed self	_____	**Ran**	_____

Tied shoes _____ **Rode a tricycle** _____

Any developmental delay? _____**Yes** ____ **No**

Language	**Yes**	**No**
Motor, Physical	**Yes**	**No**
Learning	**Yes**	**No**
Other	**Yes**	**No**

If any <u>other</u> delay, please describe:

_____

_____

Educational History of the Patient

Has patient ever had neuropsychological testing? If yes, when and by whom?
(Please bring copies to your assessment):

_____

_____

Has patient ever been diagnosed with a learning disability? If yes, what type and when:

_____

_____

Ever repeated or failed a grade: ____ **Yes** ___**No**

If patient has been HELD BACK:

How many times has patient been held back and why (grades, absences)?

|__**|**__**|** TIMES **|**__**|**__**|** GRADE <u>last time</u> held back

Reason (why?): _____

_____

_____

Please place a check next to any problem that patient currently exhibits (or caused difficulty in the past):

____ **Difficulty with reading**
____ **Difficulty with spelling**
____ **Difficulty with writing**
____ **Difficulty with arithmetic**
____ **Difficulty with other subjects (please list):** _____
____ **Dislike school**

Current School Performance (<u>check one</u>):

Failing _____
Below Average _____
Average _____
Above Average _____

Do you feel that your child/patient is properly placed in the current school/classroom: Yes ___ **No** ___

If no, please explain your concern with the current placement: _____

_____

_____

Psychiatric History of the Patient

Please indicate any illness or condition that the patient has had and their age at the time:

Patient Psychiatric History:	**Select one:**	**Age diagnosed:**
Depressive Disorder	__ Yes __ No	_____ years
Anxiety Disorder	__ Yes __ No	_____ years
ADHD	__ Yes __ No	_____ years
Obsessive Compulsive Disorder	__ Yes __ No	_____ years
Eating Disorders	__ Yes __ No	_____ years
Tourette's, Other Tic Disorder	__ Yes __ No	_____ years
Asperger's, Autism, POD	__ Yes __ No	_____ years
Other: _____	__ Yes __ No	_____ years

Has patient ever witnessed or experienced physical abuse? ____*Yes* ____*No*

Has patient ever witnessed or experienced domestic violence? ____ *Yes* ____ *No*

Has patient ever witnessed or experienced sexual abuse? ____ *Yes* ____ *No*

Has patient ever witnessed or experienced emotional abuse? ____ *Yes* ____ *No*

Has patient ever witnessed or experienced a traumatic event? ____ *Yes* ____ *No*

Have any friends or acquaintances of the patient made a suicide attempt? ____ *Yes* ____ *No*

If YES to any above questions, please explain: _____

_____

Has the patient ever received any kind of services and/or counseling outside of school? ____**Yes** ___**No**

If patient ever received services and/or counseling, what type of Service (i.e., psychiatry, psychology, counselor): ___ Yes ___ No

Doctor, Psychiatrist **Yes** **No**

Psychologist, Therapist **Yes** **No**

Counselor **Yes** **No**

Provider's name*: _____

Diagnosis: _____

Contact Number*: _____

Length of treatment: **< 1 month** **1-6 months** **6 months-2 years** **2-5 years** **+ 5 years**

If any other services, what type of Service (i.e., psychiatry, psychology, counseling): ____ Yes ____No

Doctor, Psychiatrist **Yes** **No**

Psychologist, Therapist **Yes** **No**

Counselor **Yes** **No**

Provider's name*: _____

Diagnosis: _____

Contact Number*: _____

Length of treatment: **< 1 month** **1-6 months** **6 months-2 years** **2-5 years** **+ 5 years**

Has the patient ever received treatment from any of the following Youth Anxiety Center (YAC) clinics? (Check all that apply):

_____ Washington Heights Clinic at Presbyterian Hospital

_____ CUCARD – Columbus Circle

_____ Weill Cornell Medical Center

- **Outpatient Department**
- **Partial Hospitalization Program**
- **Don't know**

____ Don't know / Refuse

____ Not applicable / Did not receive treatment there

Psychiatric Hospitalizations: ____Yes _____ No

If YES: How many times? _____

What was the reason? _____

_____

_____

Indicate the medications the patient is <u>currently</u> receiving:

Prescription medications	**Yes**	**No**
Over-the-counter drugs	**Yes**	**No**
Vitamins, dietary supplements	**Yes**	**No**

List the medicaments	**Dosage** (**mg/day, number tablets**)	**Date started** (**mm/dd/yyyy**)	**Taken consistently?**
_____	_____	_____	**Yes** **No**
_____	_____	_____	**Yes** **No**
_____	_____	_____	**Yes** **No**
_____	_____	_____	**Yes** **No**
_____	_____	_____	**Yes** **No**

Other relevant mental health treatment information: _____

_____

_____

Medical History of the Patient

Patient Medical History:	**Age of Onset:**	**Dates:**
Allergies		
__ Food Allergies (Describe): _____	_____	_____
__ Hay Fever	_____	_____
__ Household Allergies	_____	_____
__ Other (Describe): _____	_____	_____
Blood Disorders		
__ Anemia	_____	_____
__ Hemophilia	_____	_____
__ Bleeding Problems	_____	_____
__ Other (Describe): _____	_____	_____
Dermatological		
__ Acne	_____	_____
__ Eczema	_____	_____
__ Psoriasis	_____	_____
__ Hives	_____	_____
__ Other (Describe): _____	_____	_____
Cardiovascular/Pulmonary		
__ Heart Disease (Describe): _____	_____	_____

__ High/Low Blood Pressure _____ _____
__ Mitral Valve prolapse _____ _____
__ Irregular Heart Beat _____ _____ _____
__ Asthma _____ _____
__ Cystic Fibrosis _____ _____
__ Hyperventilation _____ _____
__ Other (Describe): _____ _____ _____

Conditions of Childhood

__ Chicken Pox _____ _____
__ Diphtheria _____ _____
__ German Measles _____ _____
__ Measles _____ _____
__ Mumps _____ _____
__ Whooping Cough _____ _____
__ Stuttering _____ _____
__ Other (Describe): _____ _____ _____

Endocrine

__ Thyroid Condition _____ _____
__ Diabetes: __ Type I __Type II _____ _____
__ Other (Describe): _____ _____ _____

Eye, Ear, Throat

__ Impaired Vision _____ _____
__ Impaired Hearing _____ _____
__ Frequent Earaches _____ _____
__ Ear Tubes _____ _____
__ Frequent Sore Throats/Colds _____ _____
__ Strep Infection _____ _____
__ Other (Describe): _____ _____ _____

Gastrointestinal

__ Stomachaches _____ _____
__ Constipation _____ _____
__ Diarrhea _____ _____
__ Soils Self _____ _____
__ Reflux _____ _____
__ Irritable Bowel Syndrome _____ _____
__ Crohn's Disease _____ _____
__ Other (Describe): _____ _____ _____
Any foods that you avoid? _____

Genitourinary

__ Urinary Tract Infections _____ _____
__ Kidney Problems _____ _____
__ Enuresis (Wetting) __ Day __ Night _____ _____
__ Other (Describe) _____ _____ _____

Joints and Muscles

__ Arthritis _____ _____
__ Broken Bones _____ _____
__ Bone or Joint Disease _____ _____
__ Other (Describe): _____ _____ _____

Neurological

__ Head Trauma/Injury (Describe): _____ _____ _____
__ Frequent or Severe Headaches _____ _____
__ Epilepsy _____ _____
__ Seizure/Other Seizure Disorder _____ _____
__ Tics _____ _____
__ Fainting Spells/Dizziness _____ _____
__ Loss of Consciousness _____ _____
__ Paralysis _____ _____
__ Other (Describe): _____ _____ _____

Reproductive

__ First Period _____ _____
__ Premenstrual Syndrome/Problems _____ _____
__ Irregular Cycle _____ _____
__ Other (Describe): _____ _____ _____

Other

__ Hospitalizations (Describe): _____ _____ _____
__ Surgeries (Describe): _____ _____ _____
__ Emergency Room Visit (Describe):_____ _____ _____
__ Cancer (Describe): _____ _____ _____
__ Meningitis _____ _____
__ Convulsions _____ _____
__ Other _____ _____

Has patient been hospitalized for medical reasons? ____ **Yes** ____ **No**

Has patient had any operations? ____ **Yes** ____ **No**

Has patient had any accidents? ____ **Yes** ____ **No**

Has patient ever experienced a loss of consciousness? ____ **Yes** ____ **No**

If YES to any above questions, please explain: _____

_____

_____

_____

Is there any other important thing about the patient that you would like to tell us? ___ **Yes** ____**No**

If YES, please explain: _____

_____

_____

Family Medical and Mental Health History

Please describe <u>any family history</u> of medical conditions:

Medical illness	**Select one**		**If YES, Relation to child**
Cancer	**Yes**	**No**	**____ Immediate family (parent #1, parent #2, sibling)** **____ Other family member (grandparent, aunt, cousin, etc.)**
Diabetes	**Yes**	**No**	**____ Immediate family (parent #1, parent #2, sibling)** **____ Other family member (grandparent, aunt, cousin, etc.)**
Cardiovascular Problems	**Yes**	**No**	**____ Immediate family (parent #1, parent #2, sibling)** **____ Other family member (grandparent, aunt, cousin, etc.)**
Neurological Problems	**Yes**	**No**	**____ Immediate family (parent #1, parent #2, sibling)** **____ Other family member (grandparent, aunt, cousin, etc.)**
Other: _____ _____ _____ _____	**Yes**	**No**	**____ Immediate family (parent #1, parent #2, sibling)** **____ Other family member (grandparent, aunt, cousin, etc.)**

Please describe <u>any family history</u> of psychiatric/psychological and behavioral problems:

Mental health problems	**Select one**		**If YES, specify relation to child**
Depression	**Yes**	**No**	**____ Primary Parent #1** **____ Primary Parent #2** **____ Siblings** **____ Other family member (grandparent, aunt, cousin, etc.)**
Bipolar Disorder	**Yes**	**No**	**____ Primary Parent #1** **____ Primary Parent #2** **____ Siblings** **____ Other family member (grandparent, aunt, cousin, etc.)**
Anxiety	**Yes**	**No**	**____ Primary Parent #1** **____ Primary Parent #2** **____ Siblings** **____ Other family member (grandparent, aunt, cousin, etc.)**

Obsessive Compulsive Disorder	**Yes**	**No**	**____ Primary Parent #1** **____ Primary Parent #2** **____ Siblings** **____ Other family member (grandparent, aunt, cousin, etc.)**
Panic Attacks	**Yes**	**No**	**____ Primary Parent #1** **____ Primary Parent #2** **____ Siblings** **____ Other family member (grandparent, aunt, cousin, etc.)**
Learning Problems	**Yes**	**No**	**____ Primary Parent #1** **____ Primary Parent #2** **____ Siblings** **____ Other family member (grandparent, aunt, cousin, etc.)**
Behavior Problems	**Yes**	**No**	**____ Primary Parent #1** **____ Primary Parent #2** **____ Siblings** **____ Other family member (grandparent, aunt, cousin, etc.)**
ADHD/ADD	**Yes**	**No**	**____ Primary Parent #1** **____ Primary Parent #2** **____ Siblings** **____ Other family member (grandparent, aunt, cousin, etc.)**
Autism/Asperger's	**Yes**	**No**	**____ Primary Parent #1** **____ Primary Parent #2** **____ Siblings** **____ Other family member (grandparent, aunt, cousin, etc.)**
Schizophrenia	**Yes**	**No**	**____ Primary Parent #1** **____ Primary Parent #2** **____ Siblings** **____ Other family member (grandparent, aunt, cousin, etc.)**
Mental Retardation	**Yes**	**No**	**____ Primary Parent #1** **____ Primary Parent #2** **____ Siblings** **____ Other family member (grandparent, aunt, cousin, etc.)**
Suicide Attempts	**Yes**	**No**	**____ Primary Parent #1** **____ Primary Parent #2** **____ Siblings** **____ Other family member (grandparent, aunt, cousin, etc.)**
Alcoholism	**Yes**	**No**	**____ Primary Parent #1** **____ Primary Parent #2** **____ Siblings** **____ Other family member (grandparent, aunt, cousin, etc.)**

Drug Addiction	**Yes**	**No**	**____ Primary Parent #1** **____ Primary Parent #2** **____ Siblings** **____ Other family member (grandparent, aunt, cousin, etc.)**
Legal Problems	**Yes**	**No**	**____ Primary Parent #1** **____ Primary Parent #2** **____ Siblings** **____ Other family member (grandparent, aunt, cousin, etc.)**
Other: _____	**Yes**	**No**	**____ Primary Parent #1** **____ Primary Parent #2** **____ Siblings** **____ Other family member (grandparent, aunt, cousin, etc.)**

Presenting Problem

Briefly describe your current difficulties:

When did this problem first become a concern to you?

_____

_____

When was the problem first noticed?

_____

_____

What seems to make the problem worse?

_____

_____