Family Psychosocial Screen

to answer the following our care may involve to	ng questions. Your chart reviews by q	answers will be kept stricualified persons, but neit	ctly confidential as part of your c	hild's record. Ongoing evaluations of name will ever appear in any reports.	
			opropriate. Fill in answers wh		
Are you the child's	A. Mother B. Father	C. GrandparentD. Foster Parent	E. Other relative F. Other	G. Self (Are you the patient?)	
What is the highest §	grade you have c	13 14 1	1 5 6 7 8 9 10 11 12 (Hig 5 16 17 18 19 Some co Graduate Postgraduate		
How many times ha	ve you moved in	the last year?	times		
Where is your child		House or apartment v Shelter	vith family B. House or apar D. Other		
What is your current	monthly income	e, including public assi	stance? \$		
Besides you, does ar	nyone else take c	are of the child. If yes,	, who? Yes No		
Does your child have	e any allergies to	any medications? Yes	No If yes, what?		
Has the child receive Which ones?			Yes No Where?		
			edical History		
			the following? If yes, who?		
Lung problems/asthr	ma Yes No		Heart problems Yes N	lo	
Miscarriages Yes No			Learning problems Yes No		
Nerve problems Yes No			Depression/Mental Illness Yes No		
U 1			Ŭ,	0	
How often does you	r child use a seat	Family Family Family F	lealth Habits A. Never B. Rarely C. So	metimes D. Often E. Always	
Does your child ride a bicycle? If yes, how often does he/she use a helmet?			Yes No A. Never B. Rarely C. Sometimes D. Often E. Always		
Do you feel that you	live in a safe pla	ace?	Yes No		
In the past year, have	e you ever felt th	reatened in your home	? Yes No		
In the past year, has y	our partner or oth	er family member pushe	ed you, punched you, kicked you	u, hit you or threatened to hurt you? Yes No	
What kind of gun(s)	are in your home	e?	A. Handgun B. Shotgun (C. Rifle D. Other E. None	
		? Yes No When?		Where?	
·		~		A. Excellent B. Good C. Fair D. Poor	
· ·					
How old are you? _	years old	d Are you? A. Si	ngle B. Married C. Separate	d D. Divorced E. Other	
Does anyone in you Do you currently sm	r household smo	,		s do you smoke per day?	

When you were a child
Did either parent have a drug problem? yes no
Were you raised part or all of the time by foster parents or relatives (other than your parents)? yes no
How often did your parents ground you or put you in time out? A. Frequently B. Often C. Occasionally D. Rarely E. Never
How often were you hit with an object such as a belt, board, hairbrush, stick, or cord? A. Frequently B. Often C. Occasionally D. Rarely E. Never
Do you feel you were physically abused? yes no
Do you feel you were neglected? yes no
Do you feel you were hurt in a sexual way? yes no
Did your parents ever hurt you when they were out of control? yes no
Are you ever afraid you might lose control and hurt your child? yes no
Would you like more information about free parenting programs, parent hot lines, or respite care? yes no
Would you like information about birth control or familt planning? yes no
Family Activities
How strong are your family's religious beliefs or practices? A. very strong B. moderately strong C. not strong D. n/a
What religion/church/temple?
How often do you read bedtime stories to your child? A. frequently B. often C. occasionally D. rarely E. never
How often does your family eat meals together? A. frequently B. often C. occasionally D. rarely E. never
What does your family do together for fun?
How often in the last week have you felt depressed? 0 1-2 3-4 5-7 days
In the past year, have you had two weeks or more during which you felt sad, blue, or depressed, or lost pleasure in things that you usually cared about or enjoyed? yes no
Have you had two or more years in your life when you felt depressed or sad most days, even if you felt okay sometimes? yes no
Drinking and Drugs
In the past year have you ever had a drinking problem? yes no
Have you tried to cut down on alcohol in the past year? yes no
How many drinks does it take for you to get high or get a buzz? 1 2 3 4 5 6 7 or more
Have you ever had a drug problem? If yes, which ones? cocaine heroin methadone speed marijuana other
Are you in a drug or alcohol recovery program now? yes no If yes, which one(s)?
Would you like to talk with other parents who are dealing with alcohol or drug problems? yes no
Holp and Support
Help and Support Whom can you count on to be dependable when you need help: (just write their initials and their relationship to you)
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