BEHAVIORAL INTERVIEW

Name:_____ Age:_____
Birthdate:_____ Date of Evaluation:_____
School:_____ Grade:_____ Number of classmates_____
Informant(s):_____ Counseling Time:_____

What are your major concerns?

BEHAVIORAL INVENTORY: **(Common behavioral clusters)**

Attention Deficit Hyperactivity Disorder

- **Attention span/ daydreams**
- **Distractibility**
- **Difficulty following directions/ not listening well**
- **Hyperactivity/ fidgety/ talks excessively**
- **Impulsivity (not waiting turn, butts in, blurts out answers)**
- **Organization (space/time/planning) – loses things/ notebook/bedroom**
- **Inconsistency of performance**

Oppositional

- **Defiant/quarrelsome/angry**
- **Temper tantrums**
- **Doesn't listen/uncooperative**

Conduct Disorder

- **Lying**
- **Stealing/shoplifting/ violation of rules/ law**
- **Destructive behaviors (i.e. careless/ intentional)**
- **Truancy**
- **Aggressive behavior/ Bullying**
- **Animal cruelty/ Fire setting**

Acute and Chronic Stressors (moves, new sibling, new job, illness, death, divorce, separation, bullying)

Depression

- **Sadness/ moodiness/ irritability**
- **Appetite change**
- **Social withdrawl and isolation**
- **Activity (hyperactivity, psychomotor retardation/ impaired concentration)**
- **Sleep disturbance (sleeps too much/ insomnia/day-night reversal)**
- **Suicidal ideation/ prior attempts**
- **Risk taking behaviors (substance abuse, sexual promiscuity, runaway, driving while impaired)**

Bipolar Disorder

- **Cycles of mania/ agitation/ non- stop talk/ cycles of depression/insomnia**

Anxiety

<u>Worries</u> a lot/ nervous/ high strung/ perfectionistic
Separation anxiety/ school refusal
Phobias /social anxiety
Obsessive/compulsive (repeated rituals/ thoughts)
Panic attacks
Somatic symptoms (headaches, abdominal pain, sleep problems)

Global Developmental Delay/ Autism

Poor eye contact/ lack of affection
Stereotypic behaviors (hand flapping/ twirling / rocking/head banging/ self-injury)
Ritualistic behaviors
Language problems / pragmatics/ socialization delays and lack of interest

Temperament/ Sensory Processing

Intense/negative/moody/rigid/trouble with transitions/ "slow to warm up"
Over-reacts to sensory stimulation (sounds, noise, smells, clothing, food, visual stimuli, malls, crowds, etc.)

Elimination Disorders

Enuresis
Encopresis

Sleep

Trouble falling asleep/ insomnia/ excessive / day-night reversal
Snoring/ obstructive sleep apnea

_____
_____

Eating Disorders (anorexia/ bulimia)

Substance Abuse (drugs/ alcohol)

Other_____
_____
_____
_____
_____
_____
_____
_____

School / Grade/ (learning difficulty/ behavior problems/ prior grades/ homework psycho-educational testing/ resource help/ IEP or 504 plan)

_____
_____

_____
_____
_____
_____
_____
_____

Prior Evaluations:

_____
_____
_____

PAST MEDICAL HISTORY:

Perinatal: (pregnancy/ birth hx/ neonatal hx)

Developmental milestones: history of delays

Sat alone
Crawled
Walked
Talked (first words)
Talked (short sentences)
Toilet trained
Was development different from other siblings or children?

Gross/ Fine motor skills (clumsy/ tie shoes/ buttoning/ handwriting)

Past Medical Health:

Medical (seizures/ head injury/ lead toxicity/ hearing or vision problems)

Surgical
Hospitalization
Trauma
Allergies
Medications
Immunizations
Complementary medicine
Cardiac history (structural problems/ murmurs/ chest pain/ dizziness/ syncope/ SOB/ arrhythmias/ palpitations)
Tics (motor/vocal (grunting, sniffing, coughing)
Obstructive sleep apnea/ snoring
Seizures (staring episodes)
Other

FAMILY HISTORY:

A. Mother

1. **Age**
2. **State of health**
3. **Education (grade completed)**
4. **Learning/behavior problems in school**
5. **Occupation**

B. Father

1. **Age**
2. **State of health**
3. **Education (grade completed)**
4. **Learning/behavior problems in school**
5. **Occupation**

C. Siblings

1. **Age**
2. **State of health**
3. **School performance/behaviors**

D. Anyone in family with:

1. **Learning problems**
2. **Hyperactivity or attention problems**
3. **Emotional problems (depression/ suicide, anxiety, bipolar disorder, schizophrenia, substance abuse)**
4. **Autism**
4. **Tourette Syndrome/tics**
5. **Cardiac problems (arrythmias/ sudden deaths/ cardiomyopathy)**

6. **Other**

SOCIAL HISTORY:

Who does child live at home with?

_____
_____
_____
_____

Are there any family problems? (marital, financial, substance abuse, domestic violence, communication problems between family members, Social Determinants of Health, Trauma History)

_____
_____
_____
_____

How does child get along with:

Parents/ step-parents/ grandparents? (parents work together on discipline?)

_____
_____
_____
_____

Siblings?

_____
_____
_____
_____

Peers? (bossy, aggressive, annoying, shy or withdrawn, bullying- victim or perpetrator? inappropriately touches others/ poor boundaries)
(plays with children ___same age ___younger ___older?)
(acts ___ own age ___younger ___older)

Media (computers, video games, TV, cell phones)

_____
_____
_____

Driving?

What are your child's strengths? What does your child do well? What do you like about your child?

What do you think is going on? Do you feel your child's problems are primarily:

Learning difficulty ____
Attention/hyperactivity ____
Emotional ____
Family problems ____
Teacher/child (personality conflict, poor teaching) ____
Other ____

Additional concerns? Anything not yet discussed?

What are your thoughts about medication? What have you read or heard?

DIAGNOSIS:

_____

_____

_____

RECOMMENDATIONS:

Educational Accomodations (preferential seating/break material into subunits/extra time/decrease work load/repeat directions/organizational assistance/ allow out of seat)

_____ 504 plan letter

_____ tutor

_____ resource help

_____ daily report card/ email

_____ other (speech/ OT/ PT)

Psychosocial

_____ psychoeducational testing

_____ counseling

_____ behavior plan

_____ other

Social

_____ social skills group

_____ peer activities (sports/clubs/scouts groups/camp/volunteering)

_____ other

Medical

_____ comorbidities/other medical conditions

_____ medication

_____ psychiatry referral

Followup_____

_____

Miscellaneous Recommendations/ Books/Websites/ Support groups (e.g. CHADD)