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Date: _____

I. IDENTIFYING INFORMATION			
Name of Child:		Sex:	Age:
DOB:	School:	Current Grade:	
Pediatrician:			
Address:			
City:	State:	Zip:	Contact No:

Mother's Name:		Age:	
Address:			
City:	State:	Zip:	Email:
Home Phone:	Business Phone:	Cellphone:	
Occupation:			

Father's Name:		Age:	
Address (<i>If different</i>):			
City:	State:	Zip:	Email:
Home Phone:	Business Phone:	Cellphone:	
Occupation:			

Please list the names, ages, and dates-of birth of the client's (your child's) siblings:

Name	Age	Date of Birth

II. REASONS FOR REFERRAL

- Primary Concern:

- Other concerns

III. PRENATAL HISTORY

1. Were there any complications during pregnancy and/or delivery (such as hypertension/toxemia/pre-eclampsia and/or eclampsia (seizures), prematurity, maternal Lyme disease, or infection)?

2. How old were you when your child was born?

3. Were any of the following taken during pregnancy: Beer, wine or alcohol; Coffee/Caffeine; Prescription medications; Over-the-counter and/or herbal products?

4. Were there complications related to your child's delivery?

5. What was your child's birth weight? Apgar score?

6. Were there any health complications following birth? If yes, please specify:

IV. POSTNATAL PERIOD AND INFANCY

1. Were there early infancy feeding problems?
2. Was the child colicky?
3. Were there early infancy sleep pattern difficulties?
4. Were there any problems with the infant's responsiveness (alertness)?
5. Did the child experience any health problems during infancy?
6. How active was your child as an infant?

V. DEVELOPMENTAL MILESTONES

1. At what age did (s)he sit up?
2. At what age did (s)he crawl?
3. At what age did (s)he walk?
4. At what age did (s)he speak single words (other than "mama" or "dada")?
5. At what age did (s)he string two or more words together?
6. At what age was (s)he toilet-trained? (bladder control)?
7. At what age was (s)he toilet-trained? (bowel control)?
8. Approximately how much time did toilet training take from onset to completion?

VI. MEDICAL HISTORY

1. How is his/her hearing?
2. How is his/her vision? Is he/she colorblind?
3. How is his/her gross (large) motor coordination?
4. How is his/her fine (small) motor coordination?
5. How is his/her speech, articulation, and language processing?
6. Has he had any chronic health problems (e.g., asthma, allergies, diabetes, heart condition)? If yes, please specify the onset, duration, and any residual problems as a result of the condition:
7. Has your child had any of the following: Head injury, convulsions, coma, and/or persistent high fevers?
8. Do you know or suspect that your child may be using nonprescription medications and/or alcohol?
9. Is there any history of physical or sexual abuse?
10. Does your child have difficulty sleeping at night? If so, what kind of difficult?
11. Does your child have any difficulties with eating or, more generally, with his/her appetite?

VII. EDUCATIONAL AND LEARNING CONCERNS

1. How is your child performing at school at the present time with regard to reading, math and other academic skills?
2. To the best of your knowledge, at what grade level is your child functioning in reading and mathematics?
3. Does your child complete assignments in a timely, organized fashion?
4. Does he/she understand and follow directions?
5. Is he/she generally attentive and focused in class?
6. Has your child ever had to repeat a grade?
7. Is he or she receiving any educational support services either in or outside of school? If so, please specify:
8. Briefly describe your child's experiences in

Preschool:

Elementary school:

Middle School:

High School:
9. Have your child's teacher's expressed concerns about him/her?

VIII. PEER RELATIONSHIPS

1. How does your child get along with his/her siblings?
2. Does your child seek friendships with peers?
3. Is your child sought out by peers?
4. Does your child prefer to play with children who are approximately of the same age?
5. Briefly describe any concerns about peer-related problems.

IX. PSYCHIATRIC HISTORY

1. Has your child ever evidenced difficulties in one or more of the following areas: Mood (i.e., sadness or elation), Anxiety, Impulsivity/Hyperactivity, Aggression, and/or Judgment?
2. Have you ever consulted with a mental health professional about your child? If so, please specify why:
3. Has your child ever been evaluated by a psychiatrist or psychologist? If so, briefly describe the findings:
4. Has medication ever been prescribed for psychiatric, behavioral, attentional, or learning purposes? If so, what medications and when?
5. Is there any family history of psychiatric, neurological, and/or learning disabilities in your extended family? (Please focus on first degree relatives—brothers, sisters, grandparents, etc.).

X. OTHER CONCERNS/ISSUES

(Please elaborate)

CHILD/ADOLESCENT PSYCHIATRY SCREEN (CAPS)

Child's Name: _____ Date of Birth: _____ Sex: _____
 Form Completed By: _____ Relationship to Child: _____

For each item below, check the one category that best describes your child **during the past 6 months**.

None = the child never or very rarely exhibits this behavior. **Mild** = the child exhibits this behavior approximately once per week, and few others notice or complain about this behavior. **Moderate** = the child exhibits this behavior at least three times per week, and others notice or comment on this behavior. **Severe** = the child exhibits this behavior almost daily, and multiple others complain about this behavior. **Past** = the child used to have significant problems with this behavior, but not during the past 6 months.

	None	Mild	Moderate	Severe	Past
1. Has difficulty separating from parents* (* = or major caregiver/guardian)					
2. Worries excessively about losing or harm occurring to parents*					
3. Worries about being separated from parent* (getting lost or kidnapped)					
4. Resists going to school or elsewhere because of fears of separation					
5. Resists being alone or without parents*					
6. Has difficulty going to sleep without parent nearby					
7. Physical complaints (headache, stomach ache, nausea) when anticipating separation					
8. Has discrete periods of intense fear that peak within 10 minutes					
9. Has excessive, unreasonable fear of a specific object or situation					
10. Has recurrent thoughts that cause marked distress (e.g., fears germs)					
11. Driven to perform repetitive behaviors (e.g., handwashing, doing things 3 times)					
12. Has recurrent, distressing recollections of past difficult or painful events					
13. Worries excessively about multiple things (e.g., school, family, health, etc.)					
14. Goes to the bathroom at inappropriate times or places					
15. Makes noises, and is often unaware of them					
16. Makes repetitive, sudden, non-rhythmic movements					
17. Fails to pay close attention to details or makes careless mistakes					
18. Has difficulty sustaining attention during play or school activities					
19. Does not seem to listen when spoken to directly					
20. Does not follow through on instructions; fails to finish schoolwork/chores					
21. Has difficulty organizing tasks and activities					
22. Loses things necessary for tasks or activities (toys, pencils, etc.)					
23. Is easily distracted easily by irrelevant stimuli					
24. Is forgetful in daily activities					
25. Is fidgety or squirms in seat					
26. Has difficulty remaining seated					
27. Runs or climbs excessively; is restless					
28. Talks excessively					
29. Blurts out answers before questions have been completed					

30. Has difficulty waiting turn					
31. Interrupts or intrude on others					
32. Episodes of unusually elevated or irritable mood					
33. During this episode, grandiosity or markedly inflated self-esteem (Superhero)					
34. During this episode, is more talkative than usual/seems pressured to keep talking					
35. During this episode, races from thought to thought					
36. During this episode, is very distractible					
37. During this episode, excessively involved in things (too religious, hypersexual)					
38. During this episode, dangerous involvement in pleasurable activity (spending, sex)					
39. Depressed or irritable mood most of the day, most days for at least 1 week					
40. Loss of interest in previously enjoyable activities					
41. Notable change in appetite (not when dieting or trying to gain weight)					
42. Difficulty falling or staying asleep, or sleeping excessively through the day					
43. Others notice child is sluggish or agitated most of the time					
44. Loss of energy nearly every day					
45. Feelings of worthlessness or inappropriate guilt nearly every day					
46. Thinks about dying or wouldn't care if died					
47. Smokes cigarettes, drinks alcohol, OR abuses drugs (Circle all that apply)					
48. Has bad things happen when under the influence of substances					
49. Has made unsuccessful efforts to stop using a substance					
50. Is excessively worried about gaining weight, even though underweight					
51. If female, has stopped having menstrual cycles (after regularly having)					
52. Thinks he/she is fat, even though not overweight (pulls skin and claims is fat, etc.)					
53. Engages in bingeing and purging (eats excessively, then vomits or uses laxatives)					
54. Bullies, threatens, or intimidates others					
55. Initiates physical fights					
56. Uses weapons that could harm others					
57. Has been physically cruel to animals					
58. Has shoplifted or stolen items					
59. Has deliberately set fires					
60. Has deliberately destroyed others' property					
61. Lies to obtain goods or to avoid obligations					
62. Stays out at night despite parental prohibitions					
63. Has run away from home overnight on at least two occasions					
64. Is truant from school					
65. Loses temper					
66. Actively defies or refuses to comply with adult rules					
67. Deliberately annoys others					
68. Blames others for his/her mistakes or misbehavior					
69. Easily annoyed by others					
70. Is spiteful or vindictive					
71. Has unusual thoughts that others cannot understand or believe					

72. Hears voices speaking to him/her that others don't hear					
73. Does poorly at sports or games requiring physical coordination skills					
74. Has difficulty at school with: reading, writing, math, spelling (Circle all that apply)					
75. Had delayed speech or has limited language now					
76. Avoids eye contact during conversations					
77. Does not follow when others point to objects					
78. Shows little interest in others; emotionally out of sync with others					
79. Difficulty starting, stopping conversation; continues talking after others lose interest					
80. Uses unusual phrases, possibly over and over (speaks Disney or movie lines)					
81. Does not engage in make-believe play; plays more alone than with others					
82. Unusual preoccupations with objects or unusual routines (lines up 100's of cars, etc.)					
83. Difficulty with transitions; may be inflexible about adhering to routines or rules					
84. Shows unusual physical mannerisms (hand -flapping, shrieks, objects in mouth, etc.)					
85. Unusual preoccupations (schedules, own alphabet, weather reports, etc.)					