Scoring Criteria for Family Psychosocial Screening

Under "Family Activities: are three items that screen for parental depression. Two or more positive answers (meaning the parent endorsed a troubling behavior) are considered a positive screen. When present, it may be helpful to explore other symptoms such as changes in appetite, weight, sleep, activities, energy level, ability to concentrate, feelings of hopelessness, and thoughts and plans about suicide. Reassurance about the frequency of depression is helpful, as is noting the availability of various treatment options such as psychologists, psychiatrists, family doctors, internists, and support groups.

Under "Drinking and Drugs" are seven questions that screen for parental substance abuse. A positive response to any of the first six is considered a positive screen. This should be met with further questions about frequency of use, impact on the family, and impression of the effects of parental drinking on children. Physicians' advice to quit smoking is often highly effective, but it may be unlikely that abuse of other substances can be eliminated as easily. Referrals for further assessment and treatment should be made.

Under "Family Health Habits" there are four questions assessing domestic violence. Parents who respond positively to any of these should receive further counseling, including exploration of the extent and patterns of violence, and safety issues for children (including gun storage). Parents may need assistance making escape plans and should be referred to hotlines or shelters. Clinicians should affirm that domestic violence is wrong, but not uncommon. Victims need follow-up visits and ongoing support, even if they return to the batterer. Forming a therapeutic relationship around the child's safety and well-being is recommended, since children are at risk for physical abuse in homes where there is domestic violence.

Under "When You Were a Child" are eight questions assessing parents' history of abuse. Such backgrounds predispose parents to disciplinary practices that may be abusive or too permissive. Positive responses to any of the first four questions are considered a positive screen. The last four questions help gather additional information about disciplinary techniques and parents' need for counseling and parent training.

Under "Help and Support" are questions assessing social support, a strong factor in reducing life and parenting stresses. Adequate social support helps ensure appropriate models for parenting practices and social control on disciplinary techniques. A positive screen is determined from the first three questions as having an average of fewer than two supportive persons or being less than very satisfied with their support. Referrals to parenting groups, social work services, home visitor programs, or community family support services are warranted.

Family Psychosocial Screening also assesses a number of other risk factors for developmental and behavior problems. These include frequent household moves, single parenting, three or more children in the home, less than a high school education, and unemployment. Four or more such risk factors, including mental health problems and an authoritarian parenting style (observed when parents use commands excessively or are negative and less than responsive to child-initiated interests) is associated with a substantial drop in children's intelligence and subsequent school achievement. In such cases, children should also be referred for early stimulation programs such as Head Start or a quality day care or preschool program.

Family Psychosocial Screening

This office is dedicated to providing the best possible care for your child. In order for us to serve you better, please take a few minutes to answer the following questions. Your answers will be kept strictly confidential as part of your child's medical record. Ongoing evaluations of our care may involve chart reviews by qualified persons, but neither your name, nor your child's name will ever appear in any reports.

Child's Name _____ Today's Date _____

Circle either the word or the letter for your answer where appropriate. Fill in answers where space is provided.

Are you the child's:

A. Mother B. Father. C. Grandparent D. Foster Parent
E. Other relative F. Other G. Self (Are you the patient?)

What is the highest grade you have completed?

1 2 3 4 5 6 7 8 9 10 11 12 (High School GED)
Some college or vocational school College Graduate Postgraduate

How many times have you moved in the last year?

_____ times

Where is the child living now?

A. House or apartment with family B. House or apartment with relative or friends
C. Shelter D. Other

What is your current monthly income, including public assistance? $ _____

Besides you, does anyone else take care of the child? YES NO
If yes, who?

_____

Has child received health care elsewhere? YES NO
If yes, what?

_____

Does the child have any allergies to any medications? YES NO
If yes, what?

_____

Has the child received any immunizations? YES NO
Which ones? _____
Where? _____

Has the child ever been hospitalized? YES NO
When? _____
Where? _____
Why? _____

How would you rate this child's health in general?
A. Excellent B. Good C. Fair D. Poor

Do you have any concerns about your child's behavior or development? YES NO
If yes, what:

_____

What are your main concerns about your child?

_____

How old are you? _____ years old

Are you:
A. Single C. Separated B. Married D. Divorced E. Other

Family Medical History

Does the child's mother, father, or grandparents have any of the following? If yes, who?

High blood pressure	YES NO	_____
Diabetes	YES NO	_____
Lung problems (asthma)	YES NO	_____
Heart problems	YES NO	_____
Miscarriages	YES NO	_____
Learning problems	YES NO	_____
Nerve problems	YES NO	_____
Mental Illness (depression)	YES NO	_____
Drinking problems	YES NO	_____
Drug problems	YES NO	_____
Other	YES NO	_____

(please specify) _____

Family Health Habits

How often does your child use a seatbelt (carseat)?
A. Never B. Rarely C. Sometimes D. Often E. Always

Does your child ride a bicycle? YES NO
If yes, how often does he/she use a helmet?
A. Never B. Rarely C. Sometimes D. Often E. Always

Do you feel that you live in a safe place? YES NO

In the past year, have you ever felt threatened in your home? YES NO

In the past year, has your partner or other family member pushed you, punched you, kicked you, hit you or threatened to hurt you YES NO

What kind of gun(s) are in your home
A. Handgun B. Shotgun C. Rifle D. Other E. None

Does anyone in your household smoke? YES NO

Do you currently smoke cigarettes? YES NO

If yes, how many cigarettes do you smoke per day?
_____cigarettes/day

When you were a child

Did either parent have a drug or alcohol 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 family 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 you 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? YES NO

Have you used any drugs in the last 24 hours? YES NO

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

Help and Support

Whom can you count on to be dependable when you need help: (just write their initials and their relationship to you)

A. No one B. _____ C. _____

D. _____ E. _____ F. _____

G. _____ H. _____ I. _____

How satisfied are you with their support?

A. Very satisfied B. Fairly satisfied C. A little satisfied
D. A little dissatisfied E. Fairly dissatisfied F. Very dissatisfied

Who accepts you totally, including both your best and worst points?

A. No one B. _____ C. _____

D. _____ E. _____ F. _____

G. _____ H. _____ I. _____

How satisfied are you with their support?

A. Very satisfied B. Fairly satisfied C. A little satisfied
D. A little dissatisfied E. Fairly dissatisfied F. Very dissatisfied

Whom do you feel loves you deeply?

A. No one B. _____ C. _____

D. _____ E. _____ F. _____

G. _____ H. _____ I. _____

How satisfied are you with their support?

A. Very satisfied B. Fairly satisfied C. A little satisfied
D. A little dissatisfied E. Fairly dissatisfied F. Very dissatisfied