



Kartini Clinic, P.C.

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3 - FAMILY HISTORY QUESTIONNAIRE FOR PARENTS

Patient's Name: _____ Date of appointment: ___/___/___

Current age: _____ Date of Birth: _____

Primary Care Physician: _____

How did you learn about Kartini Clinic? (please check all that apply)

- From my child's doctor (please provide name): _____
- Online (please list what site): _____
- A friend or relative
- A former patient or family of Kartini Clinic
- Other (please specify): _____

HISTORY OF PRESENT ILLNESS

Who is filling out this form?

Please list all providers your child has seen for eating problems. Please include when your child was seen and what was done.

How did you feel about that treatment?

When and how did your child's problems with food begin?

Was the onset of your child's symptoms sudden (within a few days) following an acute infection of any kind?

What about your child's eating problems have you most frightened or concerned?

Briefly describe your family's eating style and who prepares:

Breakfast?

Lunch?

Dinner?

Who is home after school when your child gets home?

Patient Name: _____ **DOB:** _____

How many times a week do you eat dinner at the table together?

How many times do you eat out per week?

Who does the grocery shopping?

Does your family keep Kosher?

Does your family eat vegetarian food only?

Are there other food restrictions your family follows?

What are your family's schedules like everyday including work hours?

To your knowledge, has your child ever taken diet pills? Laxatives? Ipecac? Water pills?

How do you find your child's weight at this point? How was it before the eating disorder started?

To your knowledge does your child ever get rid of any food by vomiting?

Does he/she ever binge (eat very large quantities of food at a time)?

To your knowledge, what is the most your child has weighed?

To your knowledge, what is the least your child has weighed at current height?

Patient Name: _____ **DOB:** _____

PREVIOUS MEDICAL HISTORY

Where was your child born? City _____ State _____ Country _____

Birth weight? _____ Premature? _____ Over-due? _____ On time? _____
Do you remember your Apgar Score? _____ If so, what was it? _____

Where did you live during the year before you got pregnant?

How old were you at the time of birth?

How many pregnancies had you had before? _____ Live births? _____

Did you have any complications?

During Pregnancy (please circle any that apply or write in your own)

Bleeding High blood pressure Diabetes Anemia Toxemia
Pre-eclampsia Seizures Blood clots Placenta problems Early water break
Fever Depression Psychological Stress Exposure to toxins/infections/substances
Other (please be specific) _____

During Birth (please circle any that apply or write in your own)

Cesarian section (C-Section) Cord around neck Very large baby Small baby
Bleeding Oxygen needed Forceps needed Breech birth Fetal Distress
Other (please be specific) _____

Postpartum – after delivery (please circle any that apply or write in your own)

Low temperature Jaundice Tremors Seizures Limpness
Poor feeding NICU (Intensive care/Special nursery) Depression in mother
Other (please be specific) _____

Patient Name: _____ **DOB:** _____

Had you been on a diet of any kind before you got pregnant? During your pregnancy?

Did you take any medication before your pregnancy? During your pregnancy?

Was your child breast fed? For how long was she/he breast fed?

How easy was he/she to feed as a small child?

Any history of strep throat?

Has he/she had any major illnesses, surgeries or hospitalizations?

Is she/he allergic to any medications? _____

Is she/he allergic to any foods? _____

List any medications your child is currently taking, including vitamins, homeopathic or herbal preparations:

Do you recall anything unusual about your child's motor development (walking, crawling, coordination)?

Fine motor development (handling a spoon and other small tools such as a crayon or pencil)?

Patient Name: _____ **DOB:** _____

Language development?

Social development?

To your knowledge, does your child smoke cigarettes? Drink alcohol? Take drugs?

If a girl, when did she start her periods? When was her last period?

About how much did she weigh at the time of her last period?

When did her mother start her periods?

Her sisters?

If a boy, when did he start to go through puberty?

Was he earlier/later/the same as his friends?

When did his dad start puberty? Was he earlier/later/the same as his friends?

To your knowledge, has your child ever had sex, voluntarily or involuntarily? If involuntarily, when did this occur and has this been reported to child protective services and/or to the police?

Patient Name: _____ **DOB:** _____

Has your child ever seen a psychiatrist or therapist?
If yes, what was the reason your child saw a psychiatrist and/or therapist?

Were you included in the therapy sessions or kept informed of progress?

When was the last time your child saw the therapist?

Has your child ever had psychological testing done? If so, when and by whom?

Has your child ever taken a medication for attention, concentration, depression, insomnia or stress? (please list):

Who prescribed the medication?

Do you give this medication or does your child take it themselves?

Has your child ever displayed any self-injurious behavior like cutting or high-risk behavior that lead to some kind of injury?

Patient Name: _____ **DOB:** _____

Has your child ever discussed suicide, made a suicide attempt, and/or been hospitalized for suicidal thoughts and/or suicidal behavior? If your child has been hospitalized: When? For how long? More than once?

Patient Name: _____ **DOB:** _____

FAMILY HISTORY

Family medical history is very important; if you have time you might want to ask your relatives some of these questions since not everyone knows everyone else's medical history.

The following are the people whose history we would like to know. The conditions we would like to know about are listed on *page 10*. The easiest way to fill out this part is to *lay the list of possible conditions next to the list of family members* and as you read through the list of conditions write in any that pertain next to the family member's name. *Please give height and approximate weight.*

• **Patient's mother – Height: _____ Weight: _____**

• **Patient's father – Height: _____ Weight: _____**

• **Patient's sisters (height and weight)**

• **Patient's brothers (height and weight)**

• **Patient's first cousins (height and weight)**

Patient Name: _____ **DOB:** _____

- **Maternal grandmother (patient's mother's mother) – Height: _____ Weight: _____**

- **Maternal grandfather (patient's mother's father) – Height: _____ Weight: _____**

- **Maternal uncles and aunts (patient's mother's brothers and sisters) – List height and weight for each:**

- **Paternal grandmother (patient's father's mother) – Height: _____ Weight: _____**

- **Paternal grandfather (patient's father's father) – Height: _____ Weight: _____**

- **Paternal uncles and aunts (patient's father's brothers and sisters) – List height and weight for each:**

Patient Name: _____ **DOB:** _____

List of possible conditions (and any other you might think of) for you to write in next to the person's name on pages 9 and 10:

- A history of heart attacks or other heart problems
- A family member who died suddenly under age 50
- Joint problems
- Someone with attention deficit disorders or related problems
- A history of weight problems
- A history of many diets
- A history of food allergies
- Currently on a diet
- Food fads
- A person who eats only a very narrow range of foods
- A person who cannot stand to have their food touching on the plate
- A person who is a fanatic exerciser
- A person who seems overly concerned with their appearance
- A person who seems overly concerned about other people's body size and shape
- A history of anorexia
- A period of time when they lost a lot of weight
- A history of bulimia
- A history of panic attacks
- Someone who washes their hands many, many times
- Someone who is afraid of germs
- A history of sleep disorders such as insomnia, nightmares, night terrors or sleep walking
- A history of anxiety, who might be afraid of unusual things such as meeting people or going outside
- A person who must have everything very tidy
- Who must have their closet color coded
- A person for whom certain numbers have special or magical significance
- A person who cannot leave the house without checking on things many times
- A person in the family who has been in a hospital for a mental illness
- Someone with learning disabilities or difficulties
- Someone with tics
- A person with diabetes
- A person with high blood pressure
- Children who died in infancy or childhood
- Someone that may have a problem with alcohol or drugs
- Depression, Seasonal affective disorder or Bipolar disorder (manic depression)
- Schizophrenia
- Autoimmune diseases such as lupus
- Rheumatoid arthritis, Rheumatic fever, M.S. or Thyroid illness
- High cholesterol
- Cancer. If so, what kind?
- Anyone who has taken medications to help them with mental or emotional problems or to control stress
- A person who has committed or attempted suicide
- Someone who 'binges' or eats huge amounts of food in one sitting
- Someone who vomits to control their weight
- A 'worrier'
- Premenstrual Syndrome (PMS)
- Someone who fits the description "perfectionist"

Patient Name: _____ **DOB:** _____

SOCIAL HISTORY

Who lives at home now? If siblings are not living at home, where are they living?

Please list all full biological siblings with gender and date of birth

Please list all half biological siblings with gender and date of birth (identify if on mother's or father's side)

Age of parents?

Parent's occupation, employer, and job contentment?

Dominant Family Values? i.e. educational achievement, financial success, humanitarian, religion.

How long have you (parents) been together? _____ If not married, what is the nature of your relationship? If divorced, how long?

Parents' previous marriages:

Patient Name: _____ **DOB:** _____

How would you describe your marital/parental relationship? If divorced or separated, describe your custody arrangement and parenting plan:

How do parents communicate with each other? What did each of you learn about parenting and communication from your respective families of origin?

Parenting styles, including similarities and differences:

How do family members communicate with each other?

How are decisions made in your family?

How are conflicts handled in your family?

Has anyone in the family spent time in jail or prison? Or ever been in trouble with the Law?

Patient Name: _____ **DOB:** _____

Does your family have a religious affiliation you would like us to know about?

Is your child involved in a religious or other social group?

List any diets family members may currently be on:

Are there any particular family issues bothering parents or your child presently?

Recent family stressors or challenges?

Parenting styles, similarities and differences?

Sibling rivalry or other issues?

What are your family strengths?

Patient Name: _____ **DOB:** _____

ACADEMIC HISTORY

What grade level? _____ Which school does your child attend?

What is their academic record like?

Does your child have a job outside of school?

Has your child ever had difficulties learning school material?

What has been their best subject or most favored interest or hobby?

Is your child involved in sports, music or art?

Would you describe your child as (circle all that apply)?

Outgoing and social Introverted, but social Shy, but has friends A loner

Has there been a difference in your child's social life since the eating disorder began?

What are the three best character traits of your child?

1) _____

2) _____

3) _____

Patient Name: _____ **DOB:** _____