

Child's Symptom History & Course

Parent/Caregiver Questionnaire

This questionnaire is designed to better understand your child's symptom history and course over time, including how symptoms first appeared, how they change, and how they are affecting daily functioning now.

Many children experience periods when symptoms are more intense and periods when they are more manageable. Families may notice that symptoms worsen or improve over time, sometimes in response to illness, physical strain, stress, or changes in routine.

In this questionnaire, a "flare" refers to a noticeable period when symptoms worsen compared to your child's usual baseline.

The information you provide will help guide clinical understanding, treatment planning, and school or support recommendations. This form is not intended to question prior diagnoses or assume a specific cause. There are no right or wrong answers—your observations as a caregiver are most important.

If you are unsure about an answer, your best estimate is perfectly acceptable.

Patient Information

Child's Name: Date of Birth: Today's Date:
Completed by: Relationship to Child:

1. Onset of Symptoms

1. Please describe when you first noticed changes in your child.

2. How quickly did these changes develop?

- Very suddenly (within 24–48 hours)
 Over several days
 Over weeks or longer

3. What were the first symptoms you noticed?

4. Did this feel like a clear change from your child's usual behavior or personality? Please explain.

2. Possible Triggers

1. In the weeks before symptoms began, did your child have any illnesses, infections, fevers, or other medical issues? Please describe.

2. Since onset, have symptoms tended to worsen after illnesses or infections?

3. Do your child's symptoms tend to worsen during periods of physical or emotional stress (such as illness, poor sleep, transitions, or travel)?

- Yes
- No
- Not sure

If you answered Yes or Not sure, please check any that you have noticed for your child.

A. Illness or Immune-Related Factors

Have symptoms started or worsened around times of illness or infection?

- Strep throat or known strep exposure (even without sore throat)
- Viral illness (cold, flu-like illness, COVID, mono, etc.)
- Ear or sinus infection
- Skin infection
- Stomach or gastrointestinal illness
- Exposure to illness at home or school
- After vaccination or significant inflammation
- Not that I am aware of

B. Physical or Body-Related Factors

Have symptoms worsened during times of physical strain or changes in the body?

- Poor or disrupted sleep
- Recovery from illness
- Puberty or hormonal changes
- Poor appetite, dehydration, or low energy
- Physical exhaustion

C. Stress, Environment, or Routine Changes

Have symptoms worsened during or after changes or stressors?

- Emotional stress
- School pressure or academic demands
- Changes in routine or transitions
- Travel
- Separation from caregivers
- Sensory overload (noise, crowds, clothing, textures)

Optional

If you noticed a pattern, please briefly describe when symptoms worsened and how long the flare lasted:

4. If yes, how long after these events do symptoms typically appear?

3. Current and Past Symptoms

1. Which symptoms occur only during flares, and which are present even when things are calmer?

2. Have your child's symptoms changed over time? (For example, new symptoms appearing or others becoming less prominent.)

Symptom Checklist

Please check all symptoms your child has experienced and indicate when they were present.

Symptom	Present at onset?		During flares?		In the past month?	
Obsessions*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compulsions*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hoarding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food refusal / avoidance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urge to overeat / food preoccupation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluid refusal / avoidance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Separation anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other anxiety, fears, phobias, panic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings* / moodiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional lability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal thoughts or behaviors*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression / sadness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oppositional behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggressive behaviors* or rage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity / impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Baby talk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental or behavioral regression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decline in school performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handwriting / copying decline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive fog or slowed thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches, stomachaches, body pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bedwetting or daytime wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary frequency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensory sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions or paranoid thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motor tics*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vocal tics*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Definitions:

Obsessions: are unwanted thoughts or images that come into your child's head. They can be scary or embarrassing or strange. Some children have thoughts of bad things happening to their parents, or of getting sick. Some children have trouble getting the thoughts out of their head.

Compulsions: are routines, rituals, or actions that your child might feel like they need to do in order to stop bad things from happening or until something is 'just so'. Some children line things up or arrange things in a certain way, or ask their parents for reassurance.

Mood swings: are when your child's mood changes quickly and frequently. Your child may go from being happy or calm to being upset about something.

Suicidal ideation/behavior: is when your child thinks or expresses not wanting to be alive anymore, or does something intentionally to hurt themselves. An example of suicidal ideation is when a child says that they want to die or would rather be dead.

Irritability: is when your child is easily annoyed or bothered by little things that would not normally upset someone.

Aggressive behaviors: can cause physical or emotional harm to others. Examples of aggressive behavior include yelling, hitting/kicking, getting into fights, and bullying others.

Hallucinations: are when your child hears or sees things that are not there in a way that seems strange. Some children hear voices or they see people or things when no one is there.

Tics (movements) or Motor tics: are sudden jerks or movements, such as forceful eye blinking or a rapid head jerk to one side or the other. Some tics might be more subtle, like scrunching the nose. They occur during otherwise normal behavior. Other examples of motor tics include jerking the head or arms or legs, or stretching the mouth or jaw in a way that seems odd or too frequent.

Tics (sounds) or Vocal tics: are sudden utterances of sounds such as throat clearing, sniffing, or words. They can be very loud or soft. Other examples of vocal tics are repeated words or noises, or coughing.

4. Course Over Time

1. How would you describe the overall pattern of symptoms?

- Single episode
- Repeated flares with improvement in between
- Ongoing/chronic symptoms

2. Between flares, does your child return to their previous level of functioning?

- Fully
- Partially
- Rarely

3. How often do flares occur?

- Less than monthly
- Monthly
- Every 2–3 months
- A few times per year
- Unclear

4. How long do symptoms usually last during a flare?

5. Your Child Before Onset

1. Before symptoms began, how would you describe your child's temperament and functioning?

2. Were there any longstanding concerns (e.g., anxiety, rigidity, learning differences) prior to onset?

6. Evaluations and Diagnoses

1. What diagnoses or explanations have been given for your child's symptoms?

2. Which explanations have felt accurate to you? Which have not?

7. Treatments Tried

1. Please list treatments your child has tried (medical, psychological, school-based, or alternative) and their effects.

2. Which treatments have helped the most?

3. Have any treatments or recommendations seemed like a poor fit for your child? Please explain.

4. How quickly does your child improve when a treatment is effective?

5. Have any treatments made symptoms worse?

8. Flares vs. Baseline

1. How is your child different during a flare compared to when symptoms are milder?

2. During flares, does your child recognize that their thoughts or behaviors are unusual or out of character?

3. Are there early warning signs that a flare is starting?

4. Do later flares look similar to earlier ones, or have they changed? Please explain.

9. Impact on Daily Life

1. How have symptoms affected school attendance, learning, or behavior?

2. What school supports or accommodations have been helpful?

3. How has this condition affected family life?