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.

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**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.

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Today’s Date</th>
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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?)

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**FAMILY MEDICAL HISTORY**

- 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

- 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  YES NO
    (asthma)
  - Heart problems  YES NO
  - Miscarriages  YES NO
  - Learning problems  YES NO
  - Nerve problems  YES NO
  - Mental Illness  YES NO
    (depression)
  - Drinking problems  YES NO
  - Drug problems  YES NO
  - Other  YES NO
    (please specify)

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**FAMILY HEALTH HABITS**

- How often does your child use a seatbelt (car seat)?
  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

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**FAMILY PSYCHOSOCIAL SCREENING**

- 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?
  If yes, who?

- Has child received health care elsewhere?
  If yes, what?

- Has the child received any immunizations?
  Which ones?
  Where?

- Has the child ever been hospitalized?
  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?
  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
**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 do 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 your 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