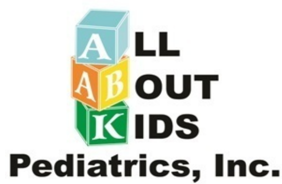

Pre-visit Parent Questionnaire: Evaluation of Academic/Behavior Concerns

Name of Child: ____ Date of Birth: ______________________

Date completed: ____________ Completed by: __________________ Relationship to child: ________________

CONCERNS:

Briefly list concerns (academic, behavioral, social, or emotional) about your child. Rank priority first.

At what age did your child first have these problems? ____

Check areas of your child's life most impacted by these concerns: School Home Social Activities

STRENGTHS:

Please list your child's strengths, abilities, accomplishments:

FAMILY INFORMATION:

Primary Household:

- Parent / Guardian: Name: ____ DOB: __________________
  Relationship to Patient: ________________________ Job: ____
- Parent / Guardian: Name: ____ DOB: __________________
  Relationship to Patient: ________________________ Job: ____
- Siblings? (names, ages) ____
- Other adults/children living at home? (names, relationships to child):
  ____

Secondary Household: Yes No

- Parent / Guardian: Name: ____ DOB: __________________
  Relationship to Patient: ________________________ Job: ____
- Parent / Guardian: Name: ____ DOB: __________________
  Relationship to Patient: ________________________ Job: ____
- Siblings? (names, ages) ____
- Other adults/children living at home? (names, relationships to child):
  ____

Do any of the following apply to your child's living situation?

- Does your child's behavior cause significant stress in the home? Yes No
- Recent major changes or stresses in the child's family or home life? Yes No
- Significant conflict with siblings or others living in the home? Yes No
- Marital problems between parents or caregivers? Yes No
- Alcohol or drug problems in the home? Yes No
- Domestic violence in the home? Yes No

PAST MEDICAL HISTORY:

Pregnancy and Birth:

1. Any difficulties with pregnancy? ______________________________
2. Did mother use any of the following during pregnancy?
   - Cigarettes/Vaping: Yes No
   - Alcohol: Yes No
   - Street drugs: Yes No
   - Prescribed medicine(s): Yes No
3. Where was child born? ______________________________
4. Was it a difficult delivery? Yes No
   - Did your baby need oxygen? Yes No
   - Vigorous Resuscitation? Yes No
   - Prolonged hospitalization after birth? Yes No
5. Birth weight _____lb _____oz
6. Premature birth? Yes No How early? ______ weeks gestation

Major Illnesses:

1. Seizures? Yes No Type ____________ Treatment ____________
2. Heart Problems? Yes No Type ____________ Treatment ____________
3. Other: ______________________________

Current Medications: ______________________________

Hospitalizations: Yes No (if yes, explain) ______________________________

Surgeries: Yes No (if yes, explain) ______________________________

Serious Injuries:

1. Head injuries? Yes No How many? __________ What age(s)? ______________
2. Poison ingestions? Yes No Name of poison(s): ____________ What age(s)? __________
3. History of physical, emotional, sexual abuse? Yes No Neglect? Yes No
   (If yes explain) ______________________________

DEVELOPMENTAL HISTORY:

Did/does your child have delays in the following areas?

Big muscle development?

- Late sitting up (after 8 months)? Yes No
- Late walking (after 15 months)? Yes No

Coordination?

- Problems throwing/catching ball? Yes No
- Problems running/jumping? Yes No
- Problems riding a bicycle? Yes No

Fine motor skills?

- Problems tying shoes? Yes No
- Problems coloring in the lines? Yes No
- Problems using scissors? Yes No
- Problems with handwriting? Yes No
- Difficult to read handwriting? Yes No

Language development?

- Late single words (after 18 mo.)? Yes No
- Late phrases (after 2 years)? Yes No
- Late sentences (after 3 years)? Yes No
- Understanding language? Yes No
- Social aspects of language? Yes No

ADHD History: Yes No

When diagnosed? (age/grade) ____________________ Who made the diagnosis? ____________________

Learning Disability: Yes No

What Type(s)? Reading / Dyslexia Writing / Dysgraphia Math / Dyscalculia Auditory Processing

When diagnosed? (age/grade) ____________________ Who made the diagnosis? ____________________

Mealtime problems:

- Dietary restrictions? Yes No
- *Specify* ________________________________
- Picky eater? Yes No
- Feeding causes stress for parent? Yes No
- Difficulty sitting through meals? Yes No
- Needs distraction (e.g. TV) to eat? Yes No

Elimination problems:

- Late in toilet training? Yes No
- Late in staying dry at night? Yes No
- Accidents after trained? Yes No
- Constipated? Yes No

Sleep problems:

- Trouble falling asleep? Yes No
- Trouble sleeping alone? Yes No
- Trouble staying asleep? Yes No
- Restless sleep? Yes No
- Snoring or mouth breathing? Yes No
- Hard to awaken? Yes No

Struggles with Routines:

Problems leaving the house in AM? Yes No

- Needs reminders? Yes No
- Gets distracted? Yes No
- Late unless prodded? Yes No
- Forgets steps of routine? Yes No

Problems with bedtime? Yes No

- Resists going to bed? Yes No
- Electronics in bedroom? Yes No
- Electronics w/in 1hr of bedtime? Yes No
- Forgets steps of routine? Yes No

SCHOOL:

1. Academic:

- Is your child below grade level? Yes No If yes, by how much? ______________________________
- Does teacher raise concerns about progress? Yes No
- Struggles or gets extra help in:

  Reading? Yes No Math? Yes No Writing? Yes No

What contributes to learning difficulties?

- Not paying attention in class Yes No
- Not finishing all homework Yes No
- Homework late or lost Yes No
- Does not study for tests Yes No
- Rushed, careless, not proofread Yes No
- Does not understand material Yes No

2. Behavior:

- Ignores or disobeys rules? Yes No
- Disrupts classroom? Yes No
- Can't sit still? Yes No
- Disrupts other children? Yes No

Does your child have an IEP or 504 Plan? Yes No If yes, IEP or 504?

If yes, please list accommodations and/or pull-out services:

SOCIAL:

- Few or no friends? Yes No
- Few party invites/playdates? Yes No
- Prefers younger/older kids? Yes No
- Immature compared to peers? Yes No
- Does not have one good friend? Yes No
- Makes friends but loses them? Yes No
- Doesn't read social cues? Yes No
- "In your face"? Yes No
- Inappropriate touching? Yes No
- Competitive or needs to win? Yes No

If problems with peer relationships, what behaviors get in the way of success?

____

INTERESTS & ACTIVITIES: ____

MEDIA USE: ____

EXECUTIVE FUNCTION:

Focus and Distractibility:

- Inattentive in non-school activities? Yes No
  - During chores? Yes No
  - Getting dressed? Yes No
- Problems with transitions? Yes No
  - Hard to stop current activity? Yes No
  - Change in usual day/week? Yes No
- Does your child daydream a lot? Yes No
- Difficulty with multiple instruction? Yes No
- Distracted easily during homework? Yes No
  - Gets up and down? Yes No
  - Needs 1:1 to stay on task? Yes No
  - Takes long time to finish work? Yes No

Activation:

- Appears unmotivated to work? Yes No
- Procrastinates with non-preferred tasks?
  - Homework: Yes No
  - Chores: Yes No

Effort:

- Hard to sustain effort on some tasks? Yes No
- Easily frustrated? Yes No
- Gives up easily or "shuts down"? Yes No

Memory:

- Short-term memory problems? Yes No
  - Loses and misplaces things? Yes No
  - Forgets things at school? Yes No
- Doesn't learn from experience? Yes No
- Forgets to turn in homework? Yes No
- Trouble remembering schoolwork? Yes No

Emotion:

- Has big reactions to small triggers? Yes No
- Has "meltdowns"? Yes No
- Has anger problems? Yes No
- Hitting or fighting? Yes No
- Breaking or throwing objects? Yes No
- Destroying property? Yes No

Activity/Impulsivity:

- Hyperactive? Yes No
- Fidgety or wiggly? Yes No
- Does your child talk excessively? Yes No
- Can't sit quietly and watch TV? Yes No
- Makes impulsive statements? Yes No
  - Problems interrupting? Yes No
  - Problems blurting out? Yes No
- You avoid restaurants with your child? Yes No
- You avoid shopping with your child? Yes No

ADDITIONAL CONCERNS:

Self-esteem:

- Your child has poor self-esteem? Yes No
- Makes self-derogatory statements? Yes No

Mood:

- Child acts sad or down? Yes No
- Child acts irritable/angry often? Yes No
- Child has been withdrawn? Yes No
- Not interested in things they enjoy? Yes No
- Recent change in appetite? Yes No
- Recent change in sleep? Yes No
- Child has weeks of being super happy, energetic, more confident than usual? Yes No
- Do any of the above cause problems with family, friends, or school? Yes No

Anxiety:

- Child has excessive worries/fears? Yes No
- Has frequent headaches? Yes No
- Has frequent stomach aches? Yes No
- Has panic attacks? Yes No
- Tries to avoid going to school? Yes No
- Hates school? Yes No
- Has difficulty meeting new people? Yes No
- Has trouble leaving parents? Yes No
- Must check/clean/organize to feel OK? Yes No
- Gets “stuck on thoughts”? Yes No
- Has excessive fear of germs? Yes No
- Do any of the above cause problems with family, friends, or school? Yes No

Oppositional or defiant behaviors:

- Problems with obedience/compliance? Yes No
  - Argumentative? Yes No
  - Oppositional or defiant? Yes No
  - Blames others? Yes No
- Does your child lie? Yes No
  - Refuses to admit responsibility? Yes No
  - Makes up untrue stories? Yes No
- Any association with a gang? Yes No
- Does your child steal? Yes No
  - Money from home/others’ toys? Yes No
- Ever been involved in antisocial behavior:
  - Setting fires? Yes No
  - Breaking and entering? Yes No
  - Physical violence with weapon? Yes No
  - Cruelty to animals or peers? Yes No
- Contact with police/juvenile authority? Yes No

Communication / Regulation:

- Trouble reading social cues/facial expression/body language? Yes No
- Problems with peer relationships? Yes No
- Intensely focused on a limited number of interests? Yes No
- Sensory issues (sound, touch, smell, texture, picky eater)? Yes No
- Repetitive behaviors (hand flapping, repeating phrases) or speech? Yes No
- Insist on special routines and upset if not followed? Yes No

Tics:

- Does your child have a muscle tic? Yes No
- Make repetitive vocal noises? Yes No

Substance Abuse:

- Ever got in trouble for using:
  - Nicotine / Vaping? Yes No
  - Alcohol? Yes No
- Ever use marijuana? Yes No
- Other illicit drugs? Yes No
- Ever been in rehab? Yes No
  - If yes, When? For what substance?
  - ______________________________________

INTERVENTIONS: What have you already done to try to help?

Prior evaluation(s) ______________________________

Tutoring ______________________________

Counseling ______________________________

Parent Supports ______________________________

Therapies ______________________________

- Occupational therapy (OT) Yes No
- Physical therapy (PT) Yes No
- Speech therapy Yes No
- Social skills Yes No

Other ______________________________

Medication Details (if applicable):

- Names / dose/ dates taken: ______________________________
- Side effects? ______________________________
- Why stopped? ______________________________ When stopped?______________

Discipline techniques that are helpful:

- Time-outs? Yes No
- Consequence system? Yes No
- Reward system? Yes No
- Restriction of privileges? Yes No
- Nothing works? Yes No
- Other? ______________________________

FAMILY HISTORY: List person affected and relationship to child.

- ADHD: Yes No ______________________________
- Learning disability: Yes No ______________________________
- Anxiety/OCD: Yes No ______________________________
- Depression: Yes No ______________________________
- Bipolar: Yes No ______________________________
- Autism: Yes No ______________________________
- Abnormal heart rhythm? Yes No Needed a pacemaker? Yes No ______________
- Substance abuse: Yes No ______________________________
- Trouble with the law: Yes No ______________________________

GOALS:

What do you want to see happen for your child?

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Screen for Child Anxiety Related Disorders (SCARED)

<u>Child Version</u> - Page 1 of 2 (To be filled out by the CHILD)

Name: ______________________ **Date**: __________________________

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you <u>for the last 3 months</u>.

		0 **Not True or Hardly Ever True**	**1** **Somewhat True or Sometimes True**	**2** **Very True or Often True**
1.	When I feel frightened, it is hard for me to breathe	o	o	o
2.	I get headaches when I am at school	o	o	o
3.	I don't like to be with people I don't know well	o	o	o
4.	I get scared if I sleep away from home	o	o	o
5.	I worry about other people liking me	o	o	o
6.	When I get frightened, I feel like passing out	o	o	o
7.	I am nervous	o	o	o
8.	I follow my mother or father wherever they go	o	o	o
9.	People tell me that I look nervous	o	o	o
10.	I feel nervous with people I don't know well	o	o	o
11.	My I get stomachaches at school	o	o	o
12.	When I get frightened, I feel like I am going crazy	o	o	o
13.	I worry about sleeping alone	o	o	o
14.	I worry about being as good as other kids	o	o	o
15.	When I get frightened, I feel like things are not real	o	o	o
16.	I have nightmares about something bad happening to my par- ents	o	o	o
17.	I worry about going to school	o	o	o
18.	When I get frightened, my heart beats fast	o	o	o
19.	I get shaky	o	o	o
20.	I have nightmares about something bad happening to me	o	o	o

Screen for Child Anxiety Related Disorders (SCARED)

<u>Child Version</u> - Page 2 of 2 (To be filled out by the CHILD)

		0 **Not True or Hardly Ever True**	**1** **Somewhat True or Sometimes True**	**2** **Very True or Often True**
21.	I worry about things working out for me	o	o	o
22.	When I get frightened, I sweat a lot	o	o	o
23.	I am a worrier	o	o	o
24.	I get really frightened for no reason at all	o	o	o
25.	I am afraid to be alone in the house	o	o	o
26.	It is hard for me to talk with people I don't know well	o	o	o
27.	When I get frightened, I feel like I am choking	o	o	o
28.	People tell me that I worry too much	o	o	o
29.	I don't like to be away from my family	o	o	o
30.	I am afraid of having anxiety (or panic) attacks	o	o	o
31.	I worry that something bad might happen to my parents	o	o	o
32.	I feel shy with people I don't know well	o	o	o
33.	I worry about what is going to happen in the future	o	o	o
34.	When I get frightened, I feel like throwing up	o	o	o
35.	I worry about how well I do things	o	o	o
36.	I am scared to go to school	o	o	o
37.	I worry about things that have already happened	o	o	o
38.	When I get frightened, I feel dizzy	o	o	o
39.	I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport)	o	o	o
40.	I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well	o	o	o
41.	I am shy	o	o	o

**For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.*

Developed by Boris Birmaher, MD, Suneeta Khetarpal, MD, Marlane Cully, MEd, David Brent, MD, and Sandra McKenzie, PhD. Western Psychiatric Institute and Clinic, University of Pgh. (10/95). Email: birmaherb@msx.upmc.edu

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version - Page 1 of 2 (To be filled out by the PARENT)

Name: ______________________ **Date**: __________________________

Directions:
Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

		0 Not True or Hardly Ever True	**1 Somewhat True or Sometimes True**	**2 Very True or Often True**
1.	When my child feels frightened, it is hard for him/her to breathe	o	o	o
2.	My child gets headaches when he/she is at school	o	o	o
3.	My child doesn't like to be with people he/she doesn't know well	o	o	o
4.	My child gets scared if he/she sleeps away from home	o	o	o
5.	My child worries about other people liking him/her	o	o	o
6.	When my child gets frightened, he/she feels like passing out	o	o	o
7.	My child is nervous	o	o	o
8.	My child follows me wherever I go	o	o	o
9.	People tell me that my child looks nervous	o	o	o
10.	My child feels nervous with people he/she doesn't know well	o	o	o
11.	My child gets stomachaches at school	o	o	o
12.	When my child gets frightened, he/she feels like he/she is going crazy	o	o	o
13.	My child worries about sleeping alone	o	o	o
14.	My child worries about being as good as other kids	o	o	o
15.	When he/she gets frightened, he/she feels like things are not real	o	o	o
16.	My child has nightmares about something bad happening to his/her parents	o	o	o
17.	My child worries about going to school	o	o	o
18.	When my child gets frightened, his/her heart beats fast	o	o	o
19.	He/she gets shaky	o	o	o
20.	My child has nightmares about something bad happening to him/her	o	o	o

Screen for Child Anxiety Related Disorders (SCARED)

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21.	My child worries about things working out for him/her	o	o	o
22.	When my child gets frightened, he/she sweats a lot	o	o	o
23.	My child is a worrier	o	o	o
24.	My child gets really frightened for no reason at all	o	o	o
25.	My child is afraid to be alone in the house	o	o	o
26.	It is hard for my child to talk with people he/she doesn't know well	o	o	o
27.	When my child gets frightened, he/she feels like he/she is choking	o	o	o
28.	People tell me that my child worries too much	o	o	o
29.	My child doesn't like to be away from his/her family	o	o	o
30.	My child is afraid of having anxiety (or panic) attacks	o	o	o
31.	My child worries that something bad might happen to his/her parents	o	o	o
32.	My child feels shy with people he/she doesn't know well	o	o	o
33.	My child worries about what is going to happen in the future	o	o	o
34.	When my child gets frightened, he/she feels like throwing up	o	o	o
35.	My child worries about how well he/she does things	o	o	o
36.	My child is scared to go to school	o	o	o
37.	My child worries about things that have already happened	o	o	o
38.	When my child gets frightened, he/she feels dizzy	o	o	o
39.	My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport)	o	o	o
40.	My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well	o	o	o
41.	My child is shy	o	o	o

Developed by Boris Birmaher, MD, Suneeta Khetarpal, MD, Marlane Cully, MEd, David Brent, MD, and Sandra McKenzie, PhD. Western Psychiatric Institute and Clinic, University of Pgh. (10/95). Email: birmaherb@msx.upmc.edu

Columbia Depression Scale (Ages 11 and over)

Present State (last 4 weeks)

TO BE COMPLETED BY TEEN

If the answer to the question is "No," circle the 0; if it is "Yes," circle the 1.
Please answer the following questions as honestly as possible.

In the last four weeks ...	No	Yes
1. Have you often felt sad or depressed?	0	1
2. Have you felt like nothing is fun for you and you just aren't interested in anything?	0	1
3. Have you often felt grouchy or irritable and often in a bad mood, when even little things would make you mad?	0	1
4. Have you lost weight, more than just a few pounds?	0	1
5. Have you lost your appetite or often felt less like eating?	0	1
6. Have you gained a lot of weight, more than just a few pounds?	0	1
7. Have you felt much hungrier than usual or eaten a lot more than usual?	0	1
8. Have you had trouble sleeping – that is, trouble falling asleep, staying asleep, or waking up too early?	0	1
9. Have you slept more during the day than you usually do?	0	1
10. Have you often felt slowed down ... like you walked or talked much slower than you usually do?	0	1
11. Have you often felt restless ... like you just had to keep walking around?	0	1
12. Have you had less energy than you usually do?	0	1
13. Has doing even little things made you feel really tired?	0	1
14. Have you often blamed yourself for bad things that happened?	0	1
15. Have you felt you couldn't do anything well or that you weren't as good looking or as smart as other people?	0	1
16. Has it seemed like you couldn't think as clearly or as fast as usual?	0	1
17. Have you often had trouble keeping your mind on your [schoolwork/work] or other things?	0	1
18. Has it often been hard for you to make up your mind or to make decisions?	0	1
19. Have you often thought about death or about people who had died or about being dead yourself?	0	1
20. Have you thought seriously about killing yourself?	0	1
21. Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?	0	1
22. Have you tried to kill yourself in the last four weeks?	0	1

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Columbia Depression Scale (Ages 11 and over)

Present State (last 4 weeks)

TO BE COMPLETED BY PARENT OF FEMALE CHILD

If the answer to the question is "No," circle the 0; if it is "Yes," circle the 1.
Please answer the following questions about your daughter (female child) as honestly as possible.

In the last four weeks ...	No	Yes
1. Has she often seemed sad or depressed?	0	1
2. Has it seemed like nothing was fun for her and she just wasn't interested in anything?	0	1
3. Has she often been grouchy or irritable and often in a bad mood, when even little things would make her mad?	0	1
4. Has she lost weight, more than just a few pounds?	0	1
5. Has it seemed like she lost her appetite or ate a lot less than usual?	0	1
6. Has she gained a lot of weight, more than just a few pounds?	0	1
7. Has it seemed like she felt much hungrier than usual or ate a lot more than usual?	0	1
8. Has she had trouble sleeping – that is, trouble falling asleep, staying asleep, or waking up too early?	0	1
9. Has she slept more during the day than she usually does?	0	1
10. Has she seemed to do things like walking or talking much more slowly than usual?	0	1
11. Has she often seemed restless ... like she just had to keep walking around?	0	1
12. Has she seemed to have less energy than she usually does?	0	1
13. Has doing even little things seemed to make her feel really tired?	0	1
14. Has she often blamed herself for bad things that happened?	0	1
15. Has she said she couldn't do anything well or that she wasn't as good looking or as smart as other people?	0	1
16. Has it seemed like she couldn't think as clearly or as fast as usual?	0	1
17. Has she often seemed to have trouble keeping her mind on her [schoolwork/work] or other things?	0	1
18. Has it often seemed hard for her to make up her mind or to make decisions?	0	1
19. Has she said she often thought about death or about people who had died or about being dead herself?	0	1
20. Has she talked seriously about killing herself?	0	1
21. Has she EVER, in her WHOLE LIFE, tried to kill herself or made a suicide attempt?	0	1
22. Has she tried to kill herself in the last four weeks?	0	1

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CHILD & ADOLESCENT PSYCHIATRY AT COLUMBIA UNIVERSITY & NYSPI

Columbia Depression Scale (Ages 11 and over)

Present State (last 4 weeks)

TO BE COMPLETED BY PARENT OF MALE CHILD

If the answer to the question is "No," circle the 0; if it is "Yes," circle the 1.
Please answer the following questions about your son (male child) as honestly as possible.

In the last four weeks ...	No	Yes
1. Has he often seemed sad or depressed?	0	1
2. Has it seemed like nothing was fun for him and he just wasn't interested in anything?	0	1
3. Has he often been grouchy or irritable and often in a bad mood, when even little things would make him mad?	0	1
4. Has he lost weight, more than just a few pounds?	0	1
5. Has it seemed like he lost his appetite or ate a lot less than usual?	0	1
6. Has he gained a lot of weight, more than just a few pounds?	0	1
7. Has it seemed like he felt much hungrier than usual or ate a lot more than usual?	0	1
8. Has he had trouble sleeping – that is, trouble falling asleep, staying asleep, or waking up too early?	0	1
9. Has he slept more during the day than he usually does?	0	1
10. Has he seemed to do things like walking or talking much more slowly than usual?	0	1
11. Has he often seemed restless ... like he just had to keep walking around?	0	1
12. Has he seemed to have less energy than he usually does?	0	1
13. Has doing even little things seemed to make him feel really tired?	0	1
14. Has he often blamed himself for bad things that happened?	0	1
15. Has he said he couldn't do anything well or that he wasn't as good looking or as smart as other people?	0	1
16. Has it seemed like he couldn't think as clearly or as fast as usual?	0	1
17. Has he often seemed to have trouble keeping his mind on his [schoolwork/work] or other things?	0	1
18. Has it often seemed hard for him to make up his mind or to make decisions?	0	1
19. Has he said he often thought about death or about people who had died or about being dead himself?	0	1
20. Has he talked seriously about killing himself?	0	1
21. Has he EVER, in his WHOLE LIFE, tried to kill himself or made a suicide attempt?	0	1
22. Has he tried to kill himself in the last four weeks?	0	1

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