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CHILD BACKGROUND QUESTIONNAIRE

GENERAL INFORMATION

Child's name:________________________ Age: _____ Date of birth:_________ Gender: M F

Name of person completing this form: _________________________________

Relationship to child: _________________________________

Who referred you? _________________________________

Date form completed: _________________________________

PURPOSE OF EVALUATION

Describe the chief concerns for which you are seeking psychological services:

Have these concerns changed (are they better, worse, etc.) since you first noticed them?

Has your child received evaluation or treatment for these concerns? If yes, when and by whom?

In what way are you hoping that I can be of help?

FAMILY INFORMATION

Please list the persons who are currently living in the home with the child:

Name	Sex	Age	Relationship to Child

Please list any family members who are no longer at home:

Name	Sex	Age	Relationship to child	When did they leave?

Mother's name: ____ Age: _________

Highest level of education completed: ________ Occupation: __________________________

Work Hours: ___________________________ Place of Employment: __________________

Father's name: ____ Age: _________

Highest level of education completed: ________ Occupation: __________________________

Work Hours: ___________________________ Place of Employment: __________________

Step-parent's name (if applicable): ________________________________ Age: _________

Highest level of education completed: ________ Occupation: __________________________

Work Hours: ___________________________ Place of Employment: __________________

Parents are (please provide date):

Married _______ Separated ________ Divorced _________ Unmarried ________ Widowed _______

If parents are divorced, who has legal custody? ____

If parents are separated or divorced, please describe visitation arrangements:

____

____

Is this child? Biological ________ Adoptive _________ Foster _________

What languages other than English are spoken in the home? ____

How long has the child been living in the current home? ____

How many times has your child moved in the past 3 years? ____

Who provides care for your child while you are at work (if applicable)? ______________________________

Please describe any family stresses your child has experienced in the last several years (e.g., death, serious illness, unemployment, marital problems, separation from parents):

____

____

____

Please list anyone in the family who is left- or "mixed-handed": ____

Please list anyone in the immediate extended family with learning difficulties:

Person (parent, brother, sister, grandparent, uncle, etc.)	**Type of Difficulty** (language, reading, math, attention, auditory processing, etc.)

Please list anyone in the immediate extended family with behavioral or emotional difficulties:

Person (parent, brother, sister, grandparent, uncle, etc.)	**Type of Difficulty** (depression, trouble with the law, drug abuse, psychosis, etc.)

Has anyone in the immediate or extended family suffered from:

Condition	**Person**	**Describe Problem**
Seizures/epilepsy?		
Any other neurological disease or disorder?		
Mental retardation?		
Any genetic disorder?		

BIRTH INFORMATION (If possible, this section should be completed by the child's mother).

Please list number of: pregnancies _______ live births _________ stillbirths __________

miscarriages _______ living children ________ deceased children __________

	Yes	**No**
Did you receive regular medical care during this pregnancy?	____	____
Did you have any problems during the pregnancy?	____	____

If yes, please describe the problem when it occurred during the pregnancy (such as diabetes, excess vomiting, bleeding, high blood pressure, toxemia, weight loss, fever, accidents): ______________
____
____

Did you smoke cigarettes during this pregnancy?	____	____

If yes, how many packs a day did you smoke? _________

Did you consume alcoholic beverages during this pregnancy?	____	____

If yes, how many days per week, on average, did you drink? ______

Did you take medications during this pregnancy?	____	____

If yes, please list:
1) _________________________________
2) _________________________________
3) _________________________________

Did you carry this baby a full 9 months?	____	____

If no, please indicate the length of pregnancy in weeks: __________

Describe type of labor (e.g., fast, long, easy, hard)? _________________

How long did labor last in hours? _____________________________

Were there any problems with the delivery?

If yes, please describe the problems (emergency Cesarean section, Slow heart rate, fever, cord around neck, etc.): ________________
____

How much did the baby weigh at birth? __________________________

How many days did the baby remain in the hospital? _______________

Did your baby require any special care shortly after birth?	____	____

If yes, please describe the type of care (oxygen, incubator, blood transfusions, bili lights-jaundice, medications, etc.): ____________
____
____

DEVELOPMENTAL INFORMATION

At approximately what age did your child:

Sit without help? ______

Crawl? ______

Walk without help? ______

Complete toilet training? ______

Say single words meaningfully? ______

Combine two or more words? ______

Use sentences? ______

Show a clear hand preference? ______

Which hand does your child prefer for writing/drawing? _______ eating? ________ sports? _______

Compared to other children, do you feel your child has had any problems with:

YES	NO	ITEM DESCRIPTION	EXPLANATION
		Fussiness as an infant?	
		Eating?	
		Sleeping?	
		Learning to talk?	
		Understanding language?	
		Unclear speech?	
		Building with blocks, playing with puzzles, drawing, etc.)?	
		Gross motor skills (walking, hopping, riding bike, etc.)?	
		Fine motor skills (fastening buttons, zippers, drawing, etc.)?	
		Toilet-training?	
		Bed-wetting?	
		Separating from parents?	
		Unusual fears?	
		Early school-related skills (naming colors, counting, alphabet)?	
		Playing or socializing with other children?	
		Unusual habits or routines?	
		Sitting still?	
		Concentrating?	
		Managing frustration?	
		Aggression?	
		Other difficulties?	

MEDICAL INFORMATION

	Yes	No
Has your child ever been hospitalized?	____	____
If yes, please list ages and reasons: ______________________________		
Has your child ever had surgery?	____	____
If yes, please list ages and reasons: ______________________________		
Has your child ever had any head injuries?	____	____
If yes, what happened and when? ______________________________		
Was the child unconscious?	____	____
Was the child dizzy?	____	____
Did the child have a headache afterward?	____	____
Did the child vomit afterward?	____	____
Has your child ever had a seizure or convulsion?	____	____
If yes, please describe, including ages and medications that were prescribed, if any: ______________________________		
Does your child have any allergies?	____	____
If yes, please describe: ______________________________		
Does your child have frequent abdominal pains or vomiting?	____	____
If yes, please describe: ______________________________		
Does your child have frequent or severe headaches?	____	____
If yes, how are they treated? ______________________________		
Does your child have any vision problems?	____	____
Please specify: ______________________________		
Does your child have any hearing problems?	____	____
Please specify: ______________________________		
Does your child have a history of frequent ear infections?	____	____
If yes, please describe how often and at what ages: ______________________________		
Is your child currently taking any medications?	____	____

If yes, please list:	Reason child is taking:
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

MEDICAL INFORMATION (cont'd)

	Yes	No
Has your child ever been evaluated by a psychologist, psychiatrist, or counselor?	____	____

If yes, please describe reasons, when, and by whom: ____________________
____
____

Has your child been given any learning, psychological, or other diagnoses?	____	____

If yes, please specify: ____
____

Please list the name, address, and telephone number of your child's primary physician/clinic:

Name: ____

Address: ____

____

Phone Number: ____

SCHOOL INFORMATION

Current school name: ____

Grade placement: ____

School address: ____

____

Telephone number: ____

Who is the appropriate contact person for details of your child's schoolwork?

____

(I will not contact this person without your signed consent and permission).

	Yes	No
Did your child attend preschool? If yes, give ages of attendance: ______________________________	____	____
Has your child ever repeated a grade? If yes, which grade(s)? ____________________________________	____	____
Does your child have an Individualized Education Plan (IEP)? If yes, when was s/he last evaluated? __________________________	____	____
Does your child have a 504 Plan? If Yes, why?______________________	____	____
Has your child ever received services in a special education classroom?	____	____

If yes, when and for what reasons (e.g., learning difficulties, emotional problems, mental retardation)? ____
____
____

Has your child received any of the following services?

Service	Yes	No	Ages or Grades
Speech/language therapy			
Physical therapy			
Occupational therapy			
Learning disabilities tutoring			
School counseling			

Over the years, how have teachers generally described your child?

What is the typical range of grades/marks your child receives on his or her report card (e.g., from A to C; B to D, etc.)?

On average, how much time does your child spend on homework each day? ____________________

Describe what type of support your child typically needs to complete homework:

DESCRIPTION OF CHILD

What do you consider your child's best qualities or strengths?

What do you consider your child's weaknesses?

Does your child prefer to play with older, younger, or same-age children? ____________________

Describe how your child typically gets along with his or her peers:

What activities does your child enjoy when not in school?

Thank you for taking the time to complete this questionnaire. I look forward to working with you.

Signature of parent/guardian: ____________________

Address: ____________________

____

Home Telephone: ____________________

Work Telephone: ____________________

Okay to leave phone messages? Yes No