CHILD/FAMILY HISTORY QUESTIONNAIRE:

Date questionnaire completed_____

Child's Name_____

Primary Language Spoken in Home _____

REFERRAL INFORMATION:

Reason for referral (What is the main problem for which you are seeking help?)

How often does the problem behavior occur? (5x/day, 2x/week, etc.)

How long has your child had this problem?

How is this problem affecting your child at home?

In school?

In peer relationships?

Has your child been seen previously for psychological or psychiatric consultation? If so, name of professional, date of service.

Has your child had any psychological or psychiatric testing completed? If so, please attach a copy.

Will you grant permission for us to contact this professional? If so, please attach consent form.

BACKGROUND INFORMATION

Medical: Is child adopted? If so, Date of adoption Age of child at adoption

Is the child a twin (or other multiple)? Identical?

How long was pregnancy? __ months.

Any complications? If so, describe

How long was labor?hours. Any complications? If so, describe

Was delivery through natural childbirth? C-section? Was delivery in the hospital? Home? Other? (Please specify)

Were there any complications during delivery? If so, describe Child's birth weight/ Height

Any complications following delivery?

How long did mother and child remain hospitalized after delivery?

Please indicate with an "x" any illness or disease which your child has had, and indicate date:

o Adverse drug reactions
o Allergies (specify: _____)
o Asthma

Frequent/recurring...
o Colds
o Gastrointestinal problems
o Headaches
o High fevers
o Influenza
o Migraine headaches
o Pneumonia
o Seizures
o Sinusitis
o Sore throats
o Strep throat
o Broken bones (specify:)
o Dizziness/Fainting
o High/Low blood pressure o Insertion/removal of tubes

Has your child ever hit his/her head?
Has your child ever been hospitalized overnight? If so, explain:

o Chickenpox
o Measles
o Mumps
o Substance abuse
o Surgeries, such as: o Appendectomy o Heart surgery
o Tonsillectomy o Other (specify:)
o Arthritis

o Cancer
o Cerebral palsy
o Diabetes
o Diphtheria
o Encephalitis
o Exposure to lead
o Meningitis
o Polio
o Tuberculosis

Name of pediatrician _____

Is your child currently on any medications or dietary supplements?
Does your child have any vision problems?
Does your child wear glasses? Contact lenses?
Does your child have any hearing problems ?
Average number of hours of sleep per night _____ Frequent waking or nightmares? _____
Do you have concerns about your child's weight? _____
Describe any unusual eating habits (picky eater, eating nonedible items, etc.)_____
Please list any known food/drug allergies: _____

Developmental

Was your child delayed in meeting any milestones (talking, walking, toilet training, reading, etc…)? If so, which ones?

If applicable, at what age did your child first demonstrate signs of puberty (breast development, menstruation, pubic hair, facial hair):

List all schools your child has attended, beginning with the most recent:

(If this is an educational concern, please attach copies of report cards)

Has your child ever repeated a grade?
Reason:

Has your child ever had problems in school? Describe

Please indicate with an "x" where you feel your child is performing academically

Below grade level
On grade level
Above grade level

Do you currently have any academic concerns? If so, please explain

Does your child enjoy attending school? If no, please explain

Has your child ever been referred for educational interventions, such as additional academic assistance, behavioral management plans, etc? If yes, please describe

Is your child currently on a 504 Plan? If so, please explain:

Is your child currently in Special Education?
Date of most recent IEP
Educational Disability Services receiving:
School:
Grade:
Date of entry:
Date of Withdrawal:

Do you feel the interventions (informal/504/Special Education) are effective? If no, please explain

Family/Home Environment
Please list all those living in child's home (including child being referred)

Please list other persons closely involved with child but not living in child's home (e.g., older siblings, grandparents, sitters, teachers, religious leaders, etc.)

Is the child currently living with both biological parents? If no, please explain

Is either parent deceased? If so, please specify

Are parents currently married?

Are parents divorced/separated? If so, when?

Which parent has custody?
How often does the non-custodial parent visit?

How long have you lived at the current address?
How often have you changed residences since the birth of this child?
Does the child share a bedroom?
With whom?

Does your child have any difficulty with siblings? If yes, please explain
Was the child ever placed or boarded away from the family? ____ If yes, where and with whom?
_____
Reason for placement

Has your child ever had difficulty or contact with legal authorities (Police, Juvenile Justice)? If yes, please describe circumstances

Please describe any religious or cultural beliefs you would like incorporated into your child's treatment. _____

Please indicate if any of the following issues are currently being experienced within the immediate family (parents, siblings):
o Marital difficulties
o Divorce/separation of parents
o Serious illness of parent, child, sibling (specify: ____ __)
o Birth of new child
o Death in family
o Recent move
o Financial problems
o Single parent
o Job loss
o Other:

Please indicate which of the following concerns have been experienced in the immediate and/or extended family (parents, siblings, aunts, uncles, cousins, grandparents). Please indicate which relative.

o Autism Spectrum Disorders
o Learning Disabilities
o Mental Retardation
o Birth Defects
o Cancer
o Diabetes
o Attention Deficit Hyperactivity Disorder (ADHD)

o Alcoholism
o Drug addiction
o Depression
o BipolarDisorder
o Suicide (threats/attempts/completed)
o Anxiety
o Phobias(specify)
o Psychiatric Hospitalizations
o High Blood Pressure
o High Cholesterol
o Heart Disease

Emotional/Behavorial Concerns:

o Misinterprets facial expressions or body language
o Overreacts to perceived insults
o Does not understand teasing, sarcasm, jokes
o Has few or no friends
o Displays attention-getting behaviors, acts like “class clown”
o Misinterprets tone of voice o Isolated from others – few group or social interactions
o Withdrawn – does not make eye contact, seems introverted, does not participate in discussions
o Emotional o Excessive crying
o Overreacts to normal situations with excessive anger, fear, sadness, etc.)
o Excessively afraid
o Excessively happy
o Gives up when challenged
o Appears depressed
o Appears excessively angry
o Does not talk Behavioral
o Excessively out of seat
o Refuses to comply with requests o Frequently off-task
o Withdrawn o Interrupts others when speaking
o Uses foul language
o Frequently fights with peers
o Engages in risky behaviors
o Associates with children that have been in trouble
o Difficulty focusing
o Poorly organized
o Experiences difficulty starting tasks
o Acts before thinking
o Can’t sit still
o Experiences difficulty planning

Name of person completing this form , relationship to child, and date: