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BACKGROUND INFORMATION

FAMILY DATA

Patient's Name: _____ Today's Date: _____

Birthdate: _____ Age: _____ Sex (circle one): Male, Female

Home Address: _____ Phone: _____

School: _____ Grade: _____

Person completing this form (Mother, Father): _____

Mother's Name: _____ Age: _____ Education: _____

Occupation: _____ Phone (Business): _____

Phone (Cell Phone): _____ Pager: _____

Father's Name: _____ Age: _____ Education: _____

Occupation: _____ Phone (Business): _____

Phone (Cell Phone): _____ Pager: _____

Stepparent's Name: _____ Age: _____ Education: _____

Occupation: _____ Phone (Business): _____

Phone (Cell Phone): _____ Pager: _____

Marital Status of Parents: _____

List all people living in the household:

Name	Relationship to Child	Age
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

PRESENTING PROBLEM

Briefly describe your child's current difficulties:

How long has this problem(s) been of concern? _____

When was the problem(s) first noticed? _____

What seems to help the problem? _____

What seems to make the problem worse? _____

Has the child received evaluation or treatment for the current problem?

If yes, when and with whom? _____

Has the child received evaluation or treatment for a related or different problem?

If yes, when and with whom? _____

Is the child on any medication at this time? _____

If yes, please note the medication and why it was prescribed:

Who referred you here? _____

EDUCATIONAL HISTORY

Place a check next to any educational problem that your child currently exhibits:

- | | |
|--------------------------------------|--------------------------------------------------|
| _____ Has difficulty with reading | _____ Has difficulty with other subjects (list): |
| _____ Has difficulty with arithmetic | _____ |
| _____ Has difficulty with spelling | _____ |
| _____ Has difficulty with writing | _____ Does not like School |

Is your child in a Special Education Program? _____

If yes, what type of class or services? _____

Has your child been held back a grade? _____

If yes, what grade and why? _____

Has your child ever received special tutoring or therapy in school? _____

If yes, please describe: _____

Did your child attend Pre-school? _____

If yes, please describe? _____

Did your child demonstrate any difficulties in pre-school? _____

If yes, please describe: _____

SOCIAL AND BEHAVIOR CHECKLIST

Place a check next to any behavior or problem your child currently exhibits. Please describe any additional information that will assist with this evaluation on the reverse side of this page.

- _____ Has difficulty with speech
- _____ Has difficulty with hearing
- _____ Has difficulty with language
- _____ Has difficulty with vision
- _____ Has difficulty with coordination
- _____ Prefers to be alone
- _____ Does not get along well with peers/siblings
- _____ Is aggressive
- _____ Is timid or shy
- _____ Wets Bed
- _____ Bites Nails
- _____ Sucks thumb
- _____ Has blank spells
- _____ Shows daredevil behavior
- _____ Gives up easily
- _____ Is more interested in things (objects) than in people (describe):

- _____ Has frequent tantrums
- _____ Has frequent nightmares
- _____ Has trouble sleeping
- _____ Sleepwalks
- _____ Rocks back and forth
- _____ Bangs Head
- _____ Holds breath
- _____ Eats poorly
- _____ Is stubborn
- _____ Has poor bowel control
- _____ Is much too active
- _____ Is clumsy
- _____ Is impulsive
- _____ Is slow to learn
- _____ Cries too frequently

Engages in behavior that could be dangerous to self or others (describe):

Has special fears, habits, or mannerisms (describe):

Other behaviors that are of concern (describe):

DEVELOPMENTAL HISTORY

During pregnancy, was mother on any medication? _____

If yes, what kind? _____

During pregnancy, did mother smoke? _____ If yes, how many cigarettes per day? _____

During pregnancy, did mother drink alcoholic beverages? _____

If yes, what did she drink? _____

Approximately how much alcohol was consumed each day? _____

During pregnancy, did mother use drugs? _____

If yes, what kind? _____

Was the child delivered by natural childbirth methods? _____

Were forceps used during delivery? _____

Was a Caesarean section performed? _____

If yes, for what reason? _____

Was the child premature? _____

If so, by how many months? _____

What was the child's birth weight? _____

Were there any delivery complications or birth defects? _____

If yes, please describe: _____

Were there any feeding problems? _____

Were there any sleeping problems? _____

As an infant, was the child quiet? _____

As an infant did the child like to be held? _____

As an infant, was the child alert? _____

Were there any special problems or remarkable issues in the growth and development of your child during the first few years (0-5 years)?

If yes, please describe: _____

The following is a list of infant and pre-school behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain, write the approximate age followed by a question mark? Describe additional pertinent information on the back of this page.

Behavior	Age	Behavior	Age
Showed response to mother	_____	Put several words together	_____
Rolled over	_____	Dressed self	_____
Sat alone	_____	Became toilet trained	_____
Crawled	_____	Stayed dry at night	_____
Walked alone	_____	Able to feed self	_____
Babbled	_____	Rode tricycle	_____
Spoke first word	_____		

CHILD'S MEDICAL HISTORY

Place a check next to any illness or condition that your child has had. When you check an item, also note the approximate date or age of the illness.

Illness or condition	Date/Age	Illness or Condition	Date/Age
_____ Measles	_____	_____ Dizziness	_____
_____ German Measles	_____	_____ Severe Headaches	_____
_____ Mumps	_____	_____ Difficulty concentrating	_____
_____ Chicken Pox	_____	_____ Memory Problems	_____
_____ Whooping Cough	_____	_____ Extreme tiredness	_____
_____ Diphtheria	_____	_____ Rheumatic fever	_____
_____ Scarlet Fever	_____	_____ Extreme Weakness	_____
_____ Meningitis	_____	_____ Epilepsy	_____
_____ Encephalitis	_____	_____ Tuberculosis	_____
_____ High Fever	_____	_____ Bone or joint disease	_____
_____ Convulsions	_____	_____ Gonorrhea or syphilis	_____
_____ Allergy	_____	_____ Anemia	_____
_____ Hay Fever	_____	_____ Jaundice/Hepatitis	_____
_____ Head Injury	_____	_____ Diabetes	_____
_____ Broken Bones	_____	_____ Cancer	_____
_____ Hospitalizations	_____	_____ High Blood Pressure	_____
_____ Operations	_____	_____ Heart Disease	_____
_____ Ear problems	_____	_____ Asthma	_____
_____ Visual Problems	_____	_____ Bleeding Problems	_____
_____ Fainting Spells	_____	_____ Eczema or hives	_____
_____ Loss of Consciousness	_____	_____ Paralysis	_____
_____ Seizures	_____	_____ Anxiety attacks	_____
_____ Depression	_____	_____ Separation anxiety	_____
_____ Suicide attempt	_____	_____ Other illness (describe)	_____

FAMILY MEDICAL HISTORY

Place a check next to any illness or condition that any member of the immediate family has had. Please note the family member's relationship to the child.

Illness or condition	Relationship to Child	Illness or condition	Relationship to Child
_____ Cancer	_____	_____ Heart Problems	_____
_____ Diabetes	_____	_____ Alcoholism	_____
_____ Drug Problem	_____	_____ Depression	_____
_____ Suicide Attempt	_____	_____ Other (describe)	_____

OTHER INFORMATION

What are your child's favorite activities?

1 _____ 2 _____
 3 _____ 4 _____
 5 _____ 6 _____

What activities would your child like to engage in more often than at present?

1 _____ 2 _____

What activities does your child like least?

1 _____ 2 _____
 3 _____ 4 _____

Has your child ever been in trouble with the law? _____

If yes, please describe on the back of this page. _____

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check next to each technique that you usually use.

Disciplinary Technique	Disciplinary Technique
<input type="checkbox"/> Ignore problem behavior	<input type="checkbox"/> Tell child to sit on a chair
<input type="checkbox"/> Time-out	<input type="checkbox"/> Send child to his/her room
<input type="checkbox"/> Scold child	<input type="checkbox"/> Take away some activity or food
<input type="checkbox"/> Threaten child	<input type="checkbox"/> Reason with child
<input type="checkbox"/> Redirect child's behavior	<input type="checkbox"/> Spank child
<input type="checkbox"/> Other (describe): _____	

What disciplinary techniques are usually effective? _____

With what type(s) of problems? _____

Which disciplinary techniques are usually ineffective? _____

With what type of problems? _____

What have you found to be the most satisfactory ways of helping your child?

What are your child's assets or strengths? _____

Is there any other information that you think may help us in working with your child?

Thank you for completing this questionnaire. This information is CONFIDENTIAL and will only be released to another person with your written consent.