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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):________________________ Other: __________________________

Father's Name: ___________________________________ Age: ______ Education: ____________

Occupation: _____________________________________ Phone (Business): ________________

Phone (Cell Phone): ________________________ Other: __________________________

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 arithmetic

_____ Has difficulty with spelling

_____ Has difficulty with writing

_____ Has difficulty with other subjects (list):

____

____

_____ 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
______ 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
______Is more interested in things (objects) than in people (describe):
____
____
____

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

______ Ignore problem behavior
______ Time-out
______ Scold child
______ Threaten child
______ Redirect child's behavior

Disciplinary Technique

______Tell child to sit on a chair
______Send child to his/her room
______Take away some activity or food
______ Reason with child
______ Spank child

______ 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.