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Child History Questionnaire

Please complete the following questionnaire to give me a general understanding of various aspects of your child's life. This information will be very helpful in determining the types of intervention that your child may need.

Child's name: _____ **Birth date:** _____ **Age:** _____

Name of the parent/guardian: _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Today's date:** _____

Home Phone: () _____ - _____ **Cell Phone:** () _____ - _____ **e-mail:** _____

Is it OK to receive email regarding appointments yes/no

it OK to leave a voicemail at home ___ **mobile** ___ **work** ___ **yes/no**

Emergency Contact's name: _____ **Phone:** () _____ - _____

Person completing this form: _____ **Relationship to child:** _____

Child's Birthplace: _____ **Religious affiliation:** _____

What are the problems that caused you to seek help for your child?

List three issues/conditions that concern you most:

- _____
- _____
- _____

When did you first notice these issues/conditions?

What worries you most if things stay the way they are?

Please list any medications that your child is taking at this time (including vitamins, natural products, etc.)

Who referred you to me? _____

Can we thank them? Yes No

Family History:

1. Child is living with: Both parents Mother Father Grandparent(s) Step-Parent Legal Gaurdian
 Other: _____

1. Is the child adopted: Yes No Child's age at adoption: _____ Country: _____

2. Status of parents' relationship:

Married Separated Divorced Widowed Never Married

How long married? _____ How long divorced? _____ Child's age at divorce: _____

If divorced:

Legal Custody: 50/50 yes no If no, primary legal parent _____

Physical Custody (please fill out percentage): Parent 1 _____ Parent 2 _____

Current Child Sharing Arrangement (how is child's time divided): _____

4. Parent 1 Name: _____ Age: _____ Work phone: _____

Cell phone: _____ Email: _____

Employment status: employed retired disabled student homemaker unemployed

When employed, what type of work does Parent 1 do? _____

Current employer is: _____ Education: _____

Parent 2 Name: _____ Age: _____

Cell phone: _____ Email: _____

Employment status: employed retired disabled student homemaker unemployed

When employed, what type of work does Parent 2 do? _____

Current employer is: _____ Education: _____

5. Step-parent 1 Name: _____ Age: _____

Cell phone: _____ Email: _____

Employment status: employed retired disabled student homemaker unemployed

When employed, what type of work does Step-Parent 1 do? _____

Current employer is: _____ Education: _____

Step-parent 2 Name: _____ Age: _____

Cell phone: _____ Email: _____

Employment status: employed retired disabled student homemaker unemployed

When employed, what type of work does Step-Parent 2 do? _____

Current employer is: _____ Education: _____

6. List the people who live at home:

Name:	Age:	Relationship to child:	Occupation:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Please provide any other information about the child's extended family that might help us understand the child's needs (e.g., medical, developmental, behavioral, educational, emotional, or psychological):

Educational History:

Current grade: _____ Name of School: _____
Phone Number: _____

What does your child do best at school?

Teacher's Name: _____

Type of school: Public Private Special

How does the school describe your child's classroom behavior? _____

What does your child do best at school? _____

Extracurricular Activities:	Current:	Past (if different):
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you feel your child is learning up to his or her potential? Yes No
If no, please indicate the academics areas that are underdeveloped:

- Mathematics: Problems with acquisition of mathematical facts
 - Difficulty performing simple arithmetic (e.g., addition, subtraction, division)
 - Difficulty understanding word-problems Other: _____

- Reading: Difficulty matching letter sounds to written symbols Careless errors
 - Difficulty pronouncing words (especially long ones) Reading is "choppy" or non-fluent
 - Difficulty with reading comprehension Other _____

My child's experience of reading: loves likes doesn't enjoy hates

- Writing: Poor pencil grip letters too big Inconsistent spacing / inconsistent handwriting poor spelling
 - Difficulty expressing ideas in writing
 - When asked to write, does minimum work required, no more than that.

- Language: difficulty finding words to name objects takes a long time to get a thought across
 - difficulties understanding or following directions even when paying attention
 - Other: _____

Please check any other concerns or problem your child has in school:

- | | | |
|--|---|--|
| <input type="checkbox"/> Does not do homework | <input type="checkbox"/> Excessive time to complete assignments | <input type="checkbox"/> Distracted |
| <input type="checkbox"/> Poor handwriting | <input type="checkbox"/> forget assignments | <input type="checkbox"/> Test Anxiety |
| <input type="checkbox"/> Does not remain seated | <input type="checkbox"/> Starts but does not finish homework | <input type="checkbox"/> Noncompliant in class |
| <input type="checkbox"/> Incomplete classroom work | <input type="checkbox"/> Excessive talking | <input type="checkbox"/> fails to check homework |
| <input type="checkbox"/> Messy/disorganized | <input type="checkbox"/> Poor attention in class | <input type="checkbox"/> Makes careless errors |

Has your child been retained a grade? Yes No. If yes, which grade? _____

Did the child attend preschool or daycare? Yes No

Name _____ preschool daycare

Name _____ preschool daycare

Were there any concerns regarding learning or behavior? Yes No

If yes, what? _____

Has the child been placed in special education programs currently or in the past? Yes No

If so, what services/program and when? _____

Does your child have:

1. Learning disability (LD): Yes No. Subjects: _____

2. Language disorder: Yes No. Type: _____

If yes, who diagnosed the Learning Disabilities? _____

Tutoring: Yes No. Where: School Other: _____

Does your child currently have a: IEP 504 Other Health Impaired (OHI) services

Birth and Developmental History:

Pregnancy:

Length of pregnancy: _____ Illness or complications while pregnant? Yes No

If yes, please explain: _____

Medications used **during** the pregnancy: _____

Substances used **during** the pregnancy: Cigarettes How many? ____ How often? (day/week): _____

Alcohol How many drinks? ____ How often?(day/week/month): _____

Drugs Please describe type and frequency of use: _____

Labor and Delivery:

Was your child's birth normal? Yes No

Were there any concerns at birth related to lack of oxygen (e.g., born "blue?"): Yes No

If so, what? _____

Perinatal History:

Birth weight: _____ Length: _____

Did mother or baby stay in Special or Intensive Care? Yes No

Please describe any problems: _____

Infancy and Early Childhood:

Please rate your child as an infant on the following behaviors. Circle 1 if the behavior on the left was present the majority of the time. Circle 5 if the behavior on the right was present the majority of the time. Stages in between are represented by 2, 3, and 4.

Quiet and content	1	2	3	4	5	Colicky and irritable
Very easy to feed	1	2	3	4	5	Daily feeding problems
Slept well	1	2	3	4	5	Frequent sleeping problems
Usually relaxed	1	2	3	4	5	Often restless
Underactive	1	2	3	4	5	Overactive
Cuddly, easy to hold	1	2	3	4	5	Did not enjoy cuddling
Easily calmed down	1	2	3	4	5	<input type="checkbox"/> Tantrums <input type="checkbox"/> head-banging
Cautious and careful	1	2	3	4	5	<input type="checkbox"/> Accident Prone <input type="checkbox"/> Daredevil
Coordinated	1	2	3	4	5	Uncoordinated
Enjoyed eye contact	1	2	3	4	5	Avoided eye contact
Liked people	1	2	3	4	5	Disliked contact with other people

Please list any other problems or comments regarding infancy or early childhood development: _____

Did any event, health condition, separation, etc., disturb early infant/mother bonding or the developing toddler/mother relationship? Yes No If yes, please explain: _____

Did any event, health condition, separation, etc., disturb early infant/father or other parent bonding or the developing toddler/father or other parent relationship? Yes No If yes, please explain _____

Please list the ages your child met these developmental milestones or denote E-early, N-normal or L-late:

Sat on own: _____ Stood up holding onto furniture: _____ Walked alone: _____

Any concerns with your child's *gross* motor development (e.g., running, skipping, jumping): _____

Fed self with spoon: _____ scribbled: _____ tied shoes: _____

Any concerns with your child's *fine* motor development (e.g., writing, buttoning, zipping): _____

Used single words: _____ Used 2+ word-sentences: _____ described a thought: _____

Any speech hearing or language difficulties? Yes No

Has your child received speech therapy? Yes No If so, what age? _____

Age Potty trained/day: _____ Age Potty trained/night: _____

Overall rate of development as compared to peers: Slow Normal Fast

Medical History:

Pediatrician's Name: _____ Phone Number: _____

Has the child been taken to the emergency room with a serious emergency, hospitalized, or had outpatient surgery since birth? Yes No

If yes, please describe condition/injury, treatment, any surgery, how long, and where.

Has your child had a head injury? Yes No If yes, how many? _____ Did they lose consciousness? Yes No

How did it happen? _____

Has your child been diagnosed with a chronic health condition? Yes No If so, what age? _____

If yes, please describe: _____

Does your child take any medication on a regular basis? Yes No

If yes, please list the name and dosage: _____

Behavioral and Mental Health History:

1. Please describe any behaviors that are particularly concerning to you or others: _____

2. Please list any unusual, traumatic, or possibly stressful events in the child's life that you think may have had an impact on his or her development and current functioning. Include incident, child's age at the time, and comments.

3. Has your child experienced any of the following:

death of a family member? parent grandparent sibling other _____

death of a friend loss of a pet(s) _____

move (what age/grade) _____

move of close/best friend (age/grade) _____

sleep problems nightmares eating issues

frequent headaches stomachaches frequent illnesses

fire setting torturing animals

4. Has the child or family received any professional mental health treatment, such as individual or family counseling, group counseling, etc.? Yes No

If yes, please give the name of previous therapist: _____

May I contact this provider? Yes No. If yes, please provide phone number: _____

5. Please circle all traits that apply to the child NOW:

impulsive worrier aggressive angry

shyness distractable irritable argumentative

cries easily fears making mistakes manipulative

6. Interactions with peers: No friends Few Friends Too shy or too timid Loses friends
 Risky behaviors Bossy, controlling Trouble making new friends Mean, aggressive

Has your child experienced any of the following:

Being teased or bullied Teasing/bullying others Peer rejection Popularity with peers

7. Has your child or any of your family members struggled with any of the following problems? Place checkmark in all that apply:

Condition	Child Current	Child Past	Mother	Father	Sibling	Other
Depression, sadness						
Anxiety, Excessive worries						
Panic Attacks						
Obsessions/Compulsions						
Tics: vocal / motor						
Headaches						
Suicidal Thoughts						
Attempted Suicide						
Learning Disability						
ADHD						
Problems with anger						
Problems with Assertiveness						
Opposition or Defiance						
Problems with the Law						
Schizophrenia/Psychosis						
Nervous Breakdown						
Heavy Alcohol Use						
Drug Use						
Eating Disorder						
Abuse/Neglect						
Self harm behaviors						
Social Anxiety						
Sleep Problems						
Other						

Does your child have any history of trauma? (i.e., sexual assault, been in an accident, witnessed violence, history of abuse) yes no

Social Media and Technology:

What forms of technology does your child use:

computer iPad/tablet cell phone gaming system(s) _____

Which Social Media sites does your child use:

texting snapchat instagram email facebook twitter Kik Youtube tumblr other(s) _____

Do you monitor you child's:

texting email snapchat instagram tumblr Youtube Vine gaming other _____
 I don't monitor any of their activity

How well do you understand the technology your child is involved in?

not at all a little moderate amount very well

Approximately how many total hours does your child use screens

(computer, phone, gaming, iPad/tablet): Weekdays _____ Weekends _____

Please list any other areas of concern.

