Child Background Questionnaire – Confidential

The following is a detailed questionnaire on your child's development, medical history, and current functioning at home and at school. This information will be integrated with the testing results to provide a better picture of your child's abilities as well as any problem areas. Please fill out this questionnaire as completely as you can:

Child's Name:_____ Today's Date:_____

Birthdate:_____ Age:_____ Grade: _____ Name of School: _____

Person filling out this form: ❑ Mother ❑ Father ❑ Stepmother ❑ Stepfather ❑ Other:_____

Biological Mother's Name: _____ Age: ____ Years of Education or degree: _____

Occupation: _____

Biological Father's Name: _____ Age: ____ Years of Education or degree: _____

Occupation: _____

Marital status of biological parents: ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

List all people currently living in your child's household:

Name	Relationship to Child	Age

If any brothers or sisters are living outside the home, list their names and ages:_____

_____

Languages spoken in the home: _____

PLEASE DESCRIBE YOUR PRIMARY CONCERNS: _____

_____

_____

_____

_____

_____

BEHAVIOR

Place a check mark (✓) next to behaviors that you believe your child exhibits to an excessive or exaggerated degree when compared to other children.

Behavior

- ❑ Stubborn
- ❑ Irritable, angry, or resentful
- ❑ Frequent tantrums
- ❑ Strikes out at others/hitting others
- ❑ Throws or destroys things
- ❑ Lying
- ❑ Stealing
- ❑ Argues with adults
- ❑ Low frustration threshold
- ❑ Daredevil behavior
- ❑ Runs away
- ❑ Needs a lot of supervision
- ❑ Impulsive (does things without thinking)
- ❑ Poor sense of danger
- ❑ Skips school
- ❑ School refusal
- ❑ Dangerous to self or others
- ❑ Purposely harms or injures self:
- ❑ Talks about killing self:
- ❑ Unusual fears, habits or mannerisms:
- ❑ Seems depressed
- ❑ Cries frequently
- ❑ Excessively worried and anxious
- ❑ Overly preoccupied with details
- ❑ Overly attached to certain objects
- ❑ Not affected by negative consequences
- ❑ Drug abuse
- ❑ Alcohol abuse
- ❑ Sexually active
- ❑ Sees things no one else can see
- ❑ Hears things no one else can see

Motor Skills

- ❑ Poor fine motor coordination
- ❑ Poor gross motor coordination

Sleeping and Eating

- ❑ Nightmares
- ❑ Trouble sleeping
- ❑ Eats poorly
- ❑ Eats excessively

Social Development

- ❑ Prefers to be alone
- ❑ Excessively shy or timid
- ❑ More interested in objects than in people
- ❑ Difficulty making friends
- ❑ Teased by other children
- ❑ Bullies other children
- ❑ Not sought out for friendship by peers
- ❑ Difficulty seeing another person's point of view
- ❑ Overly trusting of others
- ❑ Doesn't empathize with others
- ❑ Doesn't appreciate humor
- ❑ Separations anxiety/worries about parents

Other Problems

- ❑ Bladder control problems (not during seizure)
- ❑ Poor bowel control soils (self)
- ❑ Motor/vocal tics
- ❑ Overreacts to noises
- ❑ Overreacts to touch
- ❑ Excessive daydreaming and fantasy life
- ❑ Problems with taste or smell
- ❑ Headaches
- ❑ Stomachaches
- ❑ Pain_____

EDUCATION PROGRAM

Is there an individual education plan (IEP)? ❑ Yes ❑ No

Are you satisfied with your child's current learning program? If not, please explain: _____

_____

Has your child been held back a grade? ❑ No ❑ Yes (Indicate grade: ___)

Is your child in any special education classes? ❑ Yes ❑ No

If yes, please describe: _____

Is your child receiving learning assistance at school? ❑ Yes ❑ No

If yes, please describe: _____

Has your child been suspended or expelled from school? ❑ Yes ❑ No
If yes, please describe: _____

Has your child ever received tutoring? ❑ Yes ❑ No
If yes, please describe: _____

What are your child's favorite subjects?_____

Briefly describe classroom or school problems (if applicable): _____

_____

_____

_____

COGNITIVE SKILLS

Rate your child's cognitive skills relative to other children of the same age

	Above average	Average	Below Average	Severe Problem
Speech	❑	❑	❑	❑
Comprehension of speech	❑	❑	❑	❑
Problem solving	❑	❑	❑	❑
Attention span	❑	❑	❑	❑
Organizational skills	❑	❑	❑	❑
Remembering events	❑	❑	❑	❑
Remembering facts	❑	❑	❑	❑
Learning from experience	❑	❑	❑	❑
Understanding concepts	❑	❑	❑	❑
Overall intelligence	❑	❑	❑	❑

Check any specific problems:

❑ Poor articulation
❑ Difficulty finding words to express self
❑ Disorganized Speech
❑ Ungrammatical Speech
❑ Talks like a younger child
❑ Slow learner
❑ Forgets to do things
❑ Frequently loses belongings
❑ Difficulty planning tasks
❑ Doesn't foresee consequences of actions
❑ Slow thinking
❑ Difficulty with math/handling money
❑ Poor understanding of time
❑ Easily distracted

DEVELOPMENTAL HISTORY

During pregnancy, did the mother of this child:
Take any medication? ❑ Yes ❑ No
If yes, what kind? _____

Drink alcoholic beverages? ❑ Yes ❑ No
Approximately how much alcohol was consumed each day? _____

Use drugs? ❑ Yes ❑ No
If yes, what kind? How often were drugs used? _____

List any complications during pregnancy (excessive vomiting, excessive staining/blood loss, threatened miscarriage, infections, toxemia, fainting, dizziness, etc):_____

_____

Duration of pregnancy (weeks): ____ Duration of labor (hours): ____

Birth weight (lbs., oz.): _____ Height (inches): _____

Were there any indications of fetal distress? ❑ Yes ❑ No
If yes on any of other above, for what reason? _____

Check any that apply to the birth: ❑ Labor induced ❑ Forceps ❑ Breech ❑ Cesarean
If yes on any of other above, for what reason?_____

Were there any other complications? ❑ Yes ❑ No
If yes, please describe: _____

Were there any feeding problems? ❑ Yes ❑ No
If yes, please describe: _____

Were there any sleeping problems? ❑ Yes ❑ No
If yes, please describe: _____

Were there any growth or development problems during the first few years of life? ❑ Yes ❑ No
If yes, please describe: _____

Were any of the following present (to a significant degree) during infancy or the first few years of life?

❑ Unusually quiet or inactive	❑ Colic	❑ Head banging
❑ Did not like to be held or cuddled	❑ Excessive restlessness	❑ Constantly into everything
❑ Not alert	❑ Excessive sleep	❑ Difficult to sooth
❑ Diminished sleep		

Please indicate the approximate age at which your child first showed the following behaviors. Please state "Never" if your child has never shown the listed behavior.

	Age (*in months if known*)		Age (*in months if known*)
Smiled	_____	Tied Shoes	_____
Rolled over	_____	Dressed Self	_____
Sat alone	_____	Fed Self	_____
Crawled	_____	bladder trained	
Walked	_____	-daytime	_____
Ran	_____	-nighttime	_____
Babbled	_____	Bowel trained	_____
First Word	_____	Rode tricycle	_____
Sentences	_____	Rode bicycle	_____

MEDICAL HISTORY

Vision problems ❑ No ❑ Yes (describe: _____) Date of last vision exam: _____
Hearing problems ❑ No ❑ Yes (describe: _____) Date of last hearing exam: _____

List any previous assessments that your child has had:

	Dates of testing	Name of examiner
Neurological	_____	_____
Psychiatric	_____	_____
Psychological	_____	_____
Neuropsychological	_____	_____
Educational	_____	_____
Speech pathology	_____	_____

Place a check next to any illness or condition that your child has had. When you check an item, also note the approximate date of the illness (if you prefer, you can simply indicate the child's age at illness)

Illness or condition	Date(s) or Age(s)	Illness or condition	Date(s) or Age(s)
❑ Measles	_____	❑ Loss of consciousness	_____
❑ German measles	_____	❑ Poisoning	_____
❑ Mumps	_____	❑ Severe headaches	_____
❑ Chicken pox	_____	❑ Rheumatic fever	_____
❑ Diphtheria	_____	❑ Tuberculosis	_____
❑ Scarlet fever	_____	❑ Bone or joint disease	_____
❑ Meningitis	_____	❑ Sexually transmitted disease	_____
❑ Pneumonia	_____	❑ Anemia	_____
❑ Encephalitis	_____	❑ Jaundice/hepatitis	_____
❑ High fever	_____	❑ Diabetes	_____
❑ Seizures	_____	❑ Cancer	_____
❑ Allergy	_____	❑ High blood pressure	_____
❑ Hay fever	_____	❑ Heart disease	_____
❑ Injuries to head	_____	❑ Asthma	_____
❑ Broken bone	_____	❑ Bleeding problems	_____
❑ Hospitalizations	_____	❑ Eczema or hives	_____
❑ Operations	_____	❑ Physical abuse	_____
❑ Ear infections	_____	❑ Sexual abuse	_____
❑ Paralysis	_____		

Other Illnesses or Conditions: _____

_____

CURRENT MEDICATIONS

List All Currently Taking

Medication Reason taken Dosage Start date

_____

_____

_____

_____

List any form of treatment that your child has had (e.g., psychotherapy, family therapy, inpatient or residential treatment):

Type of treatment Dates Name of therapist

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

Place a check next to any illness or condition that any member of the immediate family (i.e., brothers, sisters, aunts, uncles, cousins, grandparents) has had. Please note the family member's relationship.

Condition	Relationship to Child	Condition	Relationship to Child
❑ Seizures or epilepsy	_____	❑ Suicide attempt	_____
❑ Attention deficit	_____	❑ Physical abuse	_____
❑ Hyperactivity	_____	❑ Sexual abuse	_____
❑ Learning disability	_____	❑ Childhood behavior problems	_____
❑ Mental Retardation	_____	❑ Mental Illness	_____
❑ Tic or Tourette's syndrome	_____	❑ Depression or Anxiety	_____
❑ Alcohol abuse	_____	❑ Neurological illness or disease	_____
❑ Drug abuse	_____		

❑ Other:_____

Have there been any recent stressors that you think may be contributing to your child's difficulties (e g , illness, deaths, operations, accidents, separations, divorce of parents, parent changed job, changed schools, family moved, family financial problems, remarriage, sexual trauma, other losses)?

_____

_____

_____

OTHER INFORMATION

What are your child's favorite activities?_____

_____

Has your child ever been in trouble with the law? ❑ Yes ❑ No

If yes, please describe briefly:_____

On the average, what percentage of the time does your child comply with requests? _____

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

_____

What are your child's assets or strengths? _____

_____

Spiritual beliefs?_____

Is there any other information that you think may help me in assessing your child?

_____

_____