

CHILD/ADOLESCENT BACKGROUND QUESTIONNAIRE
(Information will be included in final report)

FAMILY DATA

Child's name: _____ Today's Date: _____

Referring Physician/Party: _____

Birth date: _____ Age: _____ Sex (circle one): Male Female

Child's Ethnicity/Cultural Background: _____

Which hand does your child write with?: Right Left Either

Which foot does your child kick with?: Right Left Either

Home Address: _____ Phone: _____

School: _____ Grade: _____

Person filling out this form (circle one): Mother Father Stepmother Stepfather

Other (please explain): _____

Mother's name: _____ Age: _____ Highest Grade Completed: _____

Occupation: _____ Phone: Home _____ Business _____

Mother's handedness: Right Left

Father's name: _____ Age: _____ Highest Grade Completed: _____

Occupation: _____ Phone: Home _____ Business _____

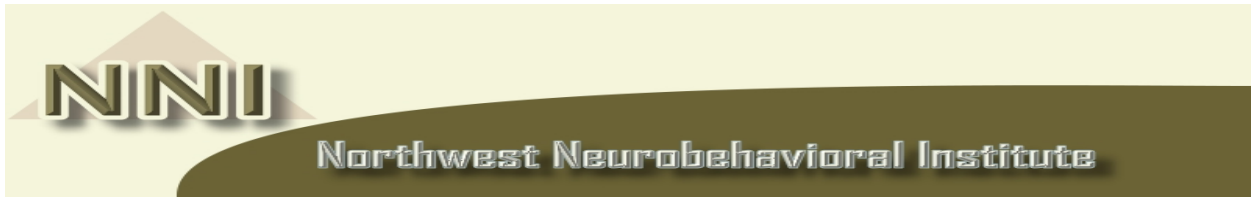
Father's handedness: Right Left

Stepparent's name: _____ Age: _____ Highest Grade Completed: _____

Occupation: _____ Phone: Home _____ Business _____

Marital Status of parents: _____

If parents are separated or divorced, how old was the child when the separation occurred? _____



List all people living in household:

Name	Relationship to Child	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary language spoken in the home: _____ Other languages spoken: _____

PRESENTING PROBLEM

Briefly describe your child's current difficulties: _____

How long has this problem been of concern to you? _____

When was the problem first noticed by you? _____

What seems to help the problem? _____

What seems to make the problem worse? _____

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

Yes ___ No ___ If yes, when and with whom? _____

Is the child on any medication at this time? Yes ___ No ___

If yes, please note kind of medication(s): _____

BEHAVIOR CHECKLIST

Place a check next to any behavior or problem that your child currently exhibits.

- | | |
|--|--|
| <input type="checkbox"/> Has difficulty with speech | <input type="checkbox"/> Has frequent tantrums |
| <input type="checkbox"/> Has difficulty with hearing | <input type="checkbox"/> Has frequent nightmares |
| <input type="checkbox"/> Has difficulty with language | <input type="checkbox"/> Has trouble sleeping |
| <input type="checkbox"/> Has difficulty with vision | (describe)_____ |
| <input type="checkbox"/> Has difficulty with fine motor coordination | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Has difficulty with gross motor coordination | <input type="checkbox"/> Rocks back and forth |
| <input type="checkbox"/> Prefers to be alone | <input type="checkbox"/> Bangs head |
| <input type="checkbox"/> Does not get along well with brothers and sisters | <input type="checkbox"/> Holds breath |
| <input type="checkbox"/> Has negativistic and independent behavior | <input type="checkbox"/> Overreacts to touch |
| <input type="checkbox"/> Is aggressive | <input type="checkbox"/> Eats poorly |
| <input type="checkbox"/> Is shy or timid | <input type="checkbox"/> Is stubborn |
| <input type="checkbox"/> Is more interested in things (objects) than in people | <input type="checkbox"/> Has poor bowel control (soils self) |
| <input type="checkbox"/> Has excessive reaction to noise or fails to react to loud noises | <input type="checkbox"/> Motor/Vocal tics |
| <input type="checkbox"/> Engages in behavior that could be dangerous to self or others (describe)_____ | <input type="checkbox"/> Is much too active |
| _____ | <input type="checkbox"/> Is clumsy |
| <input type="checkbox"/> Has special fears, habits, or mannerisms (describe)_____ | <input type="checkbox"/> Has blank spells |
| _____ | <input type="checkbox"/> Is impulsive |
| <input type="checkbox"/> Wets bed | <input type="checkbox"/> Shows daredevil behavior |
| <input type="checkbox"/> Bites nails | <input type="checkbox"/> Is slow to learn |
| <input type="checkbox"/> Sucks thumb | <input type="checkbox"/> Gives up easily |
| | <input type="checkbox"/> Daydreaming and fantasy life |
| | <input type="checkbox"/> Stealing |
| | <input type="checkbox"/> Lying |

- | | |
|--|--|
| <input type="checkbox"/> Masturbation in public places | <input type="checkbox"/> Excessive need to be first in line |
| <input type="checkbox"/> Preoccupied by certain topics (describe) _____
_____ | <input type="checkbox"/> Hand or arm flapping or unusual
finger movements near face |
| <input type="checkbox"/> Fascinated by things that spin | <input type="checkbox"/> Difficulty taking another person's
perspective |
| <input type="checkbox"/> Overly concerned with rules | <input type="checkbox"/> Poor eye contact |

All children exhibit, to some degree, the behaviors listed below. Check those that you believe your child exhibits to an excessive/exaggerated degree when compared to other children his/her own age.

- | | |
|--|---|
| <input type="checkbox"/> Hyperactivity (high activity level) | <input type="checkbox"/> Acts like he or she is driven by a motor |
| <input type="checkbox"/> Poor attention span | <input type="checkbox"/> Wears out shoes more frequently than siblings |
| <input type="checkbox"/> Impulsivity (poor self control) | |
| <input type="checkbox"/> Temper outbursts | <input type="checkbox"/> Heedless to danger |
| <input type="checkbox"/> Low frustration threshold | <input type="checkbox"/> Often engages in physically dangerous activities |
| <input type="checkbox"/> Sloppy table manners | <input type="checkbox"/> Doesn't learn from experience |
| <input type="checkbox"/> Interrupts frequently | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Difficulty playing quietly | <input type="checkbox"/> More active than siblings |
| <input type="checkbox"/> Often talks excessively | <input type="checkbox"/> A "different" child |
| <input type="checkbox"/> Often loses things | <input type="checkbox"/> Often argues with adults |
| <input type="checkbox"/> Doesn't listen | <input type="checkbox"/> Blames others for own mistakes |
| <input type="checkbox"/> Sudden outbursts or physical abuse of
other children | <input type="checkbox"/> Often touchy or easily annoyed by others |
| | <input type="checkbox"/> Is often angry or resentful |

CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY

Is child adopted? No _____ Yes _____ at age _____
 During pregnancy, were you on medication? No _____ Yes _____
 If yes, what kind(s)? _____

During pregnancy, did you smoke? No _____ Yes _____

If yes, how many cigarettes each day? _____

During pregnancy, did you drink alcoholic beverages? No _____ Yes _____

If yes, what did you drink? _____

Approximately, how much alcohol was consumed each day? _____

During pregnancy, did you use drugs? No _____ Yes _____

If yes, what kind? _____

Were there any complications during pregnancy (excessive vomiting, excessive staining/blood loss, threatened miscarriage, infections, toxemia, etc.) _____

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

Were there indications of fetal distress during labor or during birth? _____

Were forceps used during delivery? _____ Was delivery normal? _____

Was a Cesarean section performed? _____ Was delivery breach? _____

Was delivery induced? _____

If yes on any of the above, for what reason _____

Was your child premature? Yes _____ No _____

If so, by how many months? _____

Apgar Scores, if known: _____

What was your child's birth weight? _____

Were there any birth defects or complications? Yes _____ No _____

If yes, please describe: _____

Was there any depression during the immediate post-natal period? _____

What was your first impression of your baby? _____

Were there any feeding problems? Yes _____ No _____

If yes, please describe: _____

Were there any sleeping problems? Yes _____ No _____

If yes, please describe: _____

As an infant, was your child quiet? Yes _____ No _____

As an infant, did your child like to be held? Yes _____ No _____

As an infant, was your child alert? Yes _____ No _____

Were any of the following present (to a significant degree) during the first few years of life? If so, describe.

Did not enjoy cuddling _____

Was not calmed by being held or stroked _____

Colic _____ Excessive Restlessness _____

Diminished sleep _____ Frequent Headbanging _____

Constantly into everything _____

Excessive number of accidents compared to other children _____

Were there any special problems in the growth and development of your child during the first few years? Yes _____ No _____ If yes, please describe _____

Date and results of last physical examination _____

Date and results of last vision examination _____

Date and results of last hearing examination _____

The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behavior occurred, please write a question mark.

Behavior	Age	Behavior	Age
----------	-----	----------	-----

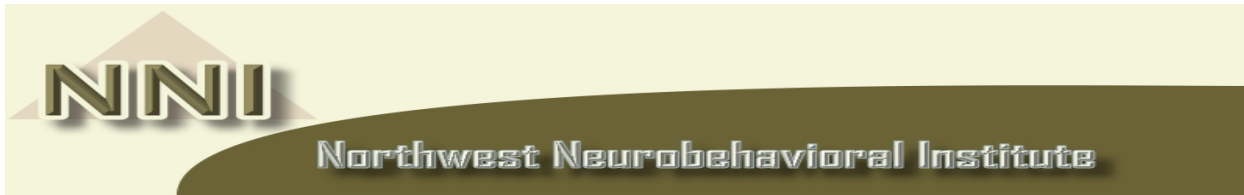
Showed response to mother	_____	Said sentences	_____
Smiled	_____	Dressed self	_____
Rolled over	_____	Bladder trained, day	_____
Sat alone	_____	Bladder trained, night	_____
Crawled	_____	Stayed dry at night	_____
Babbled	_____	Bowel trained	_____
Walked without assistance	_____	Fed self	_____
Spoke first word	_____	Rode tricycle	_____
Spoke single words (other than mama or dada)	_____	Rode bicycle (without training wheels)	_____
Said phrases	_____	Buttoned clothing	_____
Tied shoelaces	_____	Named colors	_____
Said alphabet in order	_____	Named coins	_____
Began to read	_____		

Rate your child on the following skills:

	Good	Average	Poor
Walking	_____		
Running	_____		
Throwing	_____		
Catching	_____		
Shoelace trying	_____		
Writing	_____		
Athletic abilities	_____		

Do you consider your child to understand directions and situations as well as other children his or her age? If not, why not? _____

How would you rate your child's overall level of intelligence compared to other children?



Below average _____ Average _____ Above average _____

How would you rate your child's overall level of intelligence compared to other family members?

Below average _____ Average _____ Above average _____

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.

Check	Illness/condition	Date(s)/Age(s)	Check	Illness/Condition	Date(s)/Age(s)
_____	Measles	_____	_____	Dizziness	_____
_____	German measles	_____	_____	Frequent or severe	_____
_____	Mumps	_____	_____	Headaches	_____
_____	Chicken pox	_____	_____	Difficulty concentrating	_____
_____	Whooping cough	_____	_____	Memory problems	_____
_____	Meningitis	_____	_____	Extreme tiredness or	_____
_____	Scarlet Fever	_____	_____	Weakness	_____
_____	Genetic	_____	_____	RSV	_____
	Condition				
_____	Pneumonia	_____	_____	Epilepsy	_____
_____	Encephalitis	_____	_____	Tuberculosis	_____
_____	High fever	_____	_____	Bone or joint disease	_____
_____	Seizures	_____	_____	Sexually transmitted	_____
				disease	
_____	Allergy	_____	_____	Anemia	_____
_____	Hay fever	_____	_____	Jaundice/hepatitis	_____
_____	Injuries to head	_____	_____	Diabetes	_____
_____	Broken bones	_____	_____	Cancer	_____
_____	Hospitalizations	_____	_____	High blood pressure	_____
_____	Operations	_____	_____	Heart disease	_____

_____ Otitis media	_____	_____ Ear Problems	_____
_____ Visual problems	_____	_____ Bleeding problems	_____
_____ Fainting spells	_____	_____ Eczema or hives	_____
_____ Suicide attempt	_____	_____ Concussion	_____
_____ Paralysis	_____	_____ Loss of consciousness	_____
_____ Lead Poisoning	_____	_____ Suspicion of alcohol use	_____
_____ Stomach pumped	_____	_____ Suspicion of drug use	_____
_____ Asthma	_____	_____ History of physical abuse	_____
_____ History of sexual abuse	_____		

Has your child had any psychological, neuropsychological, or educational testing?

	Dates of testing	Name of examiner and address
Psychological	_____	_____
Neuropsychological	_____	_____
Educational	_____	_____

Has your child seen a neurologist and/or a psychiatrist for evaluation? Yes _____ No _____

Date(s) of neurological examination _____

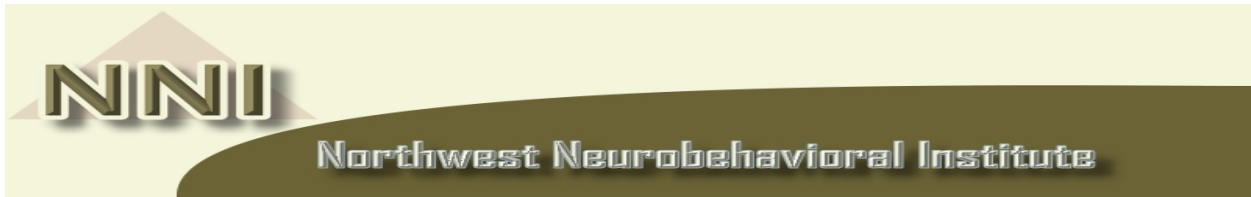
Name(s) of neurologist and address _____

Date(s) of psychiatric examination _____

Name(s) of psychiatrist and address _____

Has your child ever had any of the following forms of psychological treatment? If so, how long did it last?

_____ Individual psychotherapy	Duration of therapy	_____
_____ Group psychotherapy	Duration of therapy	_____
_____ Family therapy with child	Duration of therapy	_____



- | | |
|---|---|
| <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Doesn't sit still in his/her seat |
| <input type="checkbox"/> Frequently gets up and walks around the classroom | <input type="checkbox"/> Doesn't want to be called on |
| <input type="checkbox"/> Shouts out | <input type="checkbox"/> Difficulty following instructions |
| <input type="checkbox"/> Doesn't cooperate well in group activities | <input type="checkbox"/> Won't wait for his/her turn |
| <input type="checkbox"/> Shifts from one activity to another | <input type="checkbox"/> Difficulty sustaining attention |
| <input type="checkbox"/> Doesn't respect the rights of others | <input type="checkbox"/> Typically does better in a one to one relationship |
| <input type="checkbox"/> Doesn't pay attention during storytelling or show and tell | |

Describe briefly other classroom behavioral problems if applicable: _____

SOCIAL HISTORY

Does your child seek friendships with peers? _____

Is your child sought by peers for friendships? _____

Does your child play with children primarily his/her own age? _____ Younger _____ Older _____

Describe briefly any problems your child may have with peers _____

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. When you check an item, please note the member's relationship to the child.

Check	Condition	Relationship to child
<input type="checkbox"/>	Genetic Condition	_____
<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	Heart disease or high blood pressure	_____
<input type="checkbox"/>	Neurological condition(s)	_____
<input type="checkbox"/>	Problems with aggressiveness, defiance & oppositional behavior as a child	_____

- _____ Problems with attention, activity & impulse control as a child _____
- _____ Learning difficulties/disabilities _____
- _____ Mental retardation _____
- _____ Psychosis or schizophrenia _____
- _____ Bipolar Disorder _____
- _____ Depression _____
- _____ Anxiety disorder _____
- _____ Tics or Tourette's Disorder _____
- _____ Autism Spectrum Disorder (PDD, Autism, Asperger's) _____
- _____ Alcohol abuse _____
- _____ Drug abuse _____
- _____ Suicide attempt _____
- _____ Antisocial behavior (assaults, thefts, etc.) _____
- _____ Physical abuse _____
- _____ Sexual abuse _____
- _____ Mental abuse _____

OTHER INFORMATION

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

If yes, please describe briefly: _____

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check next to each technique that you usually use. There also is space for writing in any other disciplinary techniques that you use.

- | | |
|---------------------------------------|----------------------------------|
| _____ Ignore problem behavior | _____ Tell child to sit on chair |
| _____ Scold child | _____ Send child to his/her room |
| _____ Take away some activity or food | _____ Spank child |
| _____ Threaten child | _____ Other technique (describe) |

- _____ Reason with child _____
- _____ Redirect child's interest _____
- _____ Don't use any technique _____

Which disciplinary techniques are usually effective? _____

With what type of problem(s)? _____

What disciplinary techniques are usually ineffective? _____

With what types of problems? _____

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

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

Who typically disciplines your child? _____

To what extent are you and your spouse/partner consistent with respect to disciplinary strategies? _____

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

What are your child's assets or strengths? _____

Have there been any stressors, that I should know of (illness, deaths, operations, accidents, separations, divorce of parents, parent changed job, changed schools, family moved, family financial problems, remarriage, sexual trauma, other losses, other stressor information)? _____

