BACKGROUND QUESTIONNAIRE (FOR CHILD <18)

Today's Date: _____

Name of person completing form: _____

Identification

Patient's Name: _____

Home Address: _____

City/State/ZIP: _____

Home Phone: _____

Birthdate: _____ Age: _____ Sex: Male Female

Race/Ethnicity: _____ Religion: _____

Primary Language Spoken at Home: _____

Other Languages Spoken: _____

Family Data

Primary parent #1 Name _____ Age: _____

Gender: _____

Address (if different than patient's): _____

_____

Phone: _____ Work/Cell Phone: _____

Email Address: _____ Preferred Method of Contact: □ Phone □ Email □ Both

Education Level: _____ Occupation: _____

Place of Business: _____

Relationship to Patient: Biological Parent Adoptive Parent Step Parent Other _____

Primary Parent #2 Name: _____ Age: _____

Gender: _____

Address (if different than patient's): _____

_____

Phone: _____ Work/Cell Phone: _____

Email Address: _____ Preferred Method of Contact: □ Phone □ Email □ Both

Education Level: _____ Occupation: _____

Place of Business: _____

Relationship to Patient: Biological Parent Adoptive Parent Step Parent Other _____

If parent's are married, date of marriage: _____
If parent's are not married:

Separated _____ Date _____
Divorced _____ Date _____
Never married _____
Parent Deceased _____ Mother _____ Father _____ Date _____

Who has legal guardianship of the patient: _____

If parents are divorced or not living together:

1) What is the visitation schedule?

2) Who has custody of the child?
___ joint /shared ____ mother ____ father ___ other

3) Who has medical decision making authority for the child?

___ joint /shared ____ mother ____ father ___ other

If patient was adopted, age at which adoption occurred: _____

Other parent information: (please complete for non-custodial parent or other adult in parenting role):

Name: _____Age: _____

Gender:_____

Address (if different than patient's): _____

_____

Phone: _____ Work/Cell Phone: _____

Email Address:_____ Preferred Method of Contact: □ Phone □ Email □ Both

Education Level: _____ Occupation: _____

Place of Business: _____

Relationship to Patient: Biological Parent Adoptive Parent Step Parent Other _____

Describe amount of contact with child and role:

If patient is in foster care, name, address, and phone number of social service agency:_____

_____

List all other members of the household

Name	Relationship to Patient	Age

If any siblings are living outside the home, list their names and ages:

Educational History

Current School: _____ Grade/Level: _____

Address: _____

Teacher: _____

Type of Program: Public Private

Please list all of the schools your child has attended

School	Address	Dates/Grades Attended	Comments or Specific Reason Chose School?

Please place a check next to any problem that you/your child currently exhibit:

_____ Difficulty with reading
_____ Difficulty with spelling
_____ Difficulty with writing
_____ Difficulty with arithmetic
_____ Difficulty with other subjects (please list) _____
_____ Dislikes school

Do you feel that your child is properly placed in the current school/classroom: Yes ____ No____

If no, please explain your concern with the current placement: _____

_____

Has your child ever repeated a grade: Yes ____ No____

If yes, what grade and why: _____

_____

Have any learning disabilities ever been diagnosed? If yes, which one and when: _____

_____

Has your child ever had any neuropsychological testing? If yes, when and by whom? (Please bring copies to your assessment)

Does your child receive any of the following special services? Speech/Language Occupational Therapy Tutoring Resource Room Other _____

Presenting Problem

Briefly describe your child's current difficulties:

When did this problem first become of concern to you:_____

When was the problem first noticed:_____

What seems to make the problem worse: _____

Has your child received an evaluation or treatment for the current problem: _____ Yes _____ No

If yes, when and with whom: _____

_____

Is your child currently on medication: _____ Yes _____ No

If yes, please list medication, dosage, and date started: _____

_____

Please list any previous psychological or psychiatric treatment that your child has received

Name of Doctor, Clinic, Hospital etc.	Location	Dates	Services Provided

Please list any other medications that your child has taken for psychiatric or emotional problems

Name of Medication	Reason Prescribed	Dosage	Dates	Results/ Side Effects	Prescribing Physician

Developmental History

Duration of pregnancy (in weeks) _____

Were there complications during the pregnancy? If yes, please describe: _____

_____

Duration of labor _____

Were there complications during labor? If yes, please describe: _____

_____

Type of delivery: Vaginal C-section (please describe reason) _____

_____

What was your child's birth weight: _____

Were there any feeding problems? If yes, please describe: _____

Were there any sleeping problems? If yes, please describe: _____
As an infant, was your child a difficult baby: ____yes ____ no
As an infant, did your child like to be held: ____yes ____ no
As an infant, was your child alert: ____yes ____ no

Were there any special problems in the growth and development of your child during the first few years? If yes, please describe:_____

_____

Please indicate at what age your child first demonstrated each of the following behaviors:

___ Held up head
___ Sat alone
___ Crawled
___ Stood
___ Walked alone
___ Ran
___ Dressed self
___ Tied shoes
___ Babbled
___ Spoke first word
___ Put several words together
___ Named objects
___ Became toilet trained
___ Stayed dry at night
___ Fed self
___ Rode a tricycle

Social and Behavioral Checklist

Please put a check next to any behavior or problem that your child currently exhibits:

___ Has difficulty with speech
___ Has difficulty with language
___ Has difficulty with coordination
___ Prefers to be alone
___ Does not get along well with family members
___ Is aggressive
___ Is shy or timid
___ Is more interested in things (objects) than people
___ Engages in behavior dangerous to self or others (describe) _____
_____
___ Has special habits, fears or mannerisms (describe) _____
_____
___ Gives up easily
___ Has frequent tantrums
___ Has frequent nightmares
___ Has trouble with sleeping (describe) _____
_____
___ Rocks back and forth
___ Holds breath
___ Eats poorly
___ Is stubborn
___ Sucks thumb
___ Is much too active
___ Bites nails
___ Is impulsive
___ Shows daredevil behavior
___ Is slow to learn
___ Other (describe)_____

Name of Pediatrician/Primary Care Physician:_____
Office Location:
Phone:
Date of last physical examination:
Current Height: Current Weight:
Any recent increase or decrease in weight?
Any concerns about growth (height)?

Medical History

Place a check next to any illness or condition that your child has had, also note the approximate date or age of the illness:

Allergies:	*Age of Onset/Dates*
_____ Food Allergies (Describe) _____	_____
_____ Hay Fever	_____
_____ Household Allergies	_____
_____ Other (Describe) _____	_____
Blood Disorders:	
_____ Anemia	_____
_____ Hemophilia	_____
_____ Bleeding Problems	_____
_____ Other (Describe) _____	_____
Dermatological:	
_____ Acne	_____
_____ Eczema	_____
_____ Psoriasis	_____
_____ Hives	_____
_____ Other (Describe) _____	_____
Cardiovascular/Pulmonary:	
_____ Heart Disease (Describe) _____	_____
_____ High/Low Blood Pressure	_____
_____ Mitral Valve Prolapse	_____
_____ Irregular Heart Beat	_____
_____ Asthma	_____
_____ Cystic Fibrosis	_____
_____ Hyperventilation	_____
_____ Other (Describe) _____	_____

Conditions of Childhood: *Age of Onset/Dates*

_____ Chicken Pox _____
_____ Diphtheria _____
_____ German Measles _____
_____ Measles _____
_____ Mumps _____
_____ Whooping Cough _____
_____ Stuttering _____
_____ Other (Describe) _____ _____

Endocrine:

_____ Thyroid Condition _____
_____ Diabetes: ___ Type I ___ Type II _____
_____ Other (Describe) _____ _____

Eye, Ear, Throat:

_____ Impaired Vision _____
_____ Impaired Hearing _____
_____ Frequent Earaches _____
_____ Ear Tubes _____
_____ Frequent Sore Throats/Colds _____
_____ Strep Infection _____
_____ Other (Describe) _____ _____

Gastrointestinal:

_____ Stomachaches _____
_____ Constipation _____
_____ Diarrhea _____
_____ Soils Self _____
_____ Reflux _____
_____ Irritable Bowel Syndrome _____
_____ Crohn's Disease _____
_____ Other (Describe) _____ _____
Any foods that your child avoids?_____

Genitourinary:

_____ Urinary Tract Infections _____
_____ Kidney Problems _____
_____ Enuresis (Wetting) _____ Day _____ Night _____
_____ Other (Describe) _____ _____

Joints and Muscles:

_____ Arthritis _____
_____ Broken Bones _____
_____ Bone or Joint Disease _____
_____ Other (Describe) _____ _____

Neurological:

_____ Head Trauma/Injury (Describe) _____ _____
_____ Frequent or Severe Headaches _____
_____ Epilepsy _____
_____ Seizure/Other Seizure Disorder _____
_____ Tics _____
_____ Fainting Spells/Dizziness _____
_____ Loss of Consciousness _____
_____ Paralysis _____
_____ Other (Describe) _____ _____

Reproductive:	*Age of Onset/Dates*
_____ First Period	_____
_____ Premenstrual Syndrome/Problems	_____
_____ Irregular Cycle	_____
_____ Other (Describe) _____	_____

Other:	
_____ Hospitalizations (Describe) _____	_____
_____ Surgeries (Describe) _____	_____
_____ Emergency Room Visit (Describe) _____	_____
_____ Cancer (Describe) _____	_____
_____ Meningitis	_____
_____ Convulsions	_____
_____ Other	_____

Family Medical History

Place a check next to any illness or condition that any member of your immediate family has had. If you check an item, please note the family member's relationship to the child.

Medical Conditions:	
_____ Cancer	Family member(s): _____
_____ Diabetes	Family member(s): _____
_____ Cardiovascular Problems	Family member(s): _____
_____ Neurological Problems	Family member(s): _____
_____ Other	Family member(s): _____

Psychological/Behavioral Problems:	
_____ Depression	Family member(s): _____
_____ Bipolar Disorder	Family member(s): _____
_____ Anxiety	Family member(s): _____
_____ Obsessive-Compulsive	Family member(s): _____
_____ Panic Attacks	Family member(s): _____
_____ Learning Problems	Family member(s): _____
_____ Behavior Problems	Family member(s): _____
_____ ADHD/ADD	Family member(s): _____
_____ Autism/Aspergers	Family member(s): _____
_____ Schizophrenia	Family member(s): _____
_____ Mental Retardation	Family member(s): _____
_____ Suicide Attempts	Family member(s): _____
_____ Alcoholism	Family member(s): _____
_____ Drug Addiction	Family member(s): _____
_____ Legal Problems	Family member(s): _____
_____ Other	Family member(s): _____

Please provide specific information regarding any of the conditions that you checked for family history, including onset, treatment, and any impact on family functioning:

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 he/she does at present?

1. _____ 2. _____ 3. _____

What activities does your child like least?

1. _____ 2. _____ 3. _____

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: _____

_____

_____

_____

What disciplinary techniques are usually the most effective: _____

_____

_____

_____

What disciplinary techniques are usually ineffective: _____

_____

_____

_____

What are your child's assets or strengths: _____

_____

_____

_____

Is there any other information that you thin may be helpful for us to know to best help your child: _____

_____

_____