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CHILD and FAMILY HISTORY

Child's Name:______________________ Age:_______ Date of Birth:__________

Gender Identity: ________

Child's Address:____

Street City Zip

FATHER:______________________________ If not biological father, give relationship:__________

Address (if different):______________________ DOB:______________

Father's home phone:________ Work Phone:________ Email: ____________Age:______

MOTHER:______________________________ If not biological mother, give relationship:__________

Address (if different):______________________ DOB:______________

Mother's home phone:________ Work Phone:________ Email: ____________ Age:______

STEPMOTHER/STEPFATHER:____

Address:__________________________________ DOB:______________

Stepparent's home phone:________ Work Phone:________ Email: ________ Age: ______

WHO ELSE IS IN THE FAMILY?

NAME	AGE	BIRTH DATE	GRADE/OCCUPATION	WHERE LIVING	RELATIONSHIP

Who is (are) the legal custodian(s) of the child? ______________________________

Who referred you for treatment? ______________________________________

Child's Physician: ______________________________ Phone:__________

Who completed this questionnaire? __________________________ Date:________

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1. What medical, physical, behavioral, academic, emotional, or other concerns do you have about your child?
   a. ______________________________
   b. ______________________________
   c. ______________________________
   d. ______________________________

2. When did you first become concerned about your child? ______________________________
____
____
____

3. What do you think is the cause of the current concern(s)? ______________________________
____
____
____

4. List all professionals and agencies that have been involved in the current concern(s). Give dates of contact. Do you feel this help was beneficial?

______________________________ Yes ________ No ______
Professional/Agency Dates of contact Beneficial?

______________________________ Yes ________ No ______
Professional/Agency Dates of contact Beneficial?

5. Do you feel that the child is aware of the concern(s)? ______________________________

   If yes, how is this awareness expressed? ______________________________

6. Do mother and father agree on the existence or extent of the concern(s)? ______________________________

   If not, please explain: ______________________________

7. Do both parents agree that the child needs treatment? ______________________________

   If no, please explain: ______________________________

8. Describe your physical environment (apt, house, yard, etc.): ______________________________
____

What are your expectations from therapy? What would you like to know?

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CHILD'S MEDICAL HISTORY

Child's Physician: ______________________________ Physician's Address: ___________________________
Physician's Phone: __________________________ Last Date of Child's Physical: ___________________

YEAR		YEAR	
	Meningitis		Allergies
	Encephalitis		Asthma
	Ear Infection (How many?)		Chronic Constipation
	Hepatitis		Frequent Respiratory Infections (8+ yr)
	Poisoning		Failure to Thrive
	Accident/Serious Injury		Blows to Head or Loss of Consciousness
	Hospitalized		Surgery
	Soiling (Encopresis)		Wetting (Enuresis)

Please provide additional information about your child's medical history and expand on anything noted above. Describe age, frequency, degree of illness, etc.:

Current Medications, if any (include dosage):

INFANCY AND EARLY DEVELOPMENT

PREGNANCY

During what month did you receive your first prenatal care? _________ Duration of pregnancy, months: _______

During the pregnancy:	*Yes*	*No*		*Yes*	*No*
Did you take any medications?			Did you smoke cigarettes?		
Did you drink any alcohol?			Did you use drugs?		
Did you have any X-rays?			Were you hospitalized?		

Please describe any items checked "yes" in the space below.

DELIVERY AND NURSERY STAY

Place of Birth: ____ Hospital: ____

Length of Stay: Baby: __________________________ Mother: ________________________________

Birth Weight: ______________________ Birth Length: __________________________ Apgars: _____________________

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Yes	*No*	
		Was labor unusually long? If so, how many hours?
		Was delivery aided by instruments?
		Was the child born by cesarean section?
		Was the child yellow (jaundiced) during the first week?
		Was the child administered oxygen at birth?
		Were there any other problems, other than above, with the baby?
		Did the mother have any problems during or immediately after delivery?
		Did the baby have seizures?

Please describe any problems during the pregnancy, labor, or delivery:

INFANT DEVELOPMENT

Yes	*No*	
		Was your child breast fed?
		Did your child have any special feeding problems in early infancy? If so, explain:
		Did your child have any major problems in eating during the preschool period? (i.e. Chewing, swallowing, choking, or refusal to eat) If so, describe:
		Were there sleeping difficulties? If so, describe:
		Was your child fussy?
		Is there anything you would change about your child's feeding habits and/or diet? Please explain:

DEVELOPMENTAL MILESTONES

When did your child?:

Age (months)		*Age (months)*	
	Establish eye contact		Walk alone
	Smile responsively		Play pat-a-cake
	Recognize parents		Speak first word(s)
	Hold head erect		Use two word sentences
	Roll over		Feed self (spoon)
	Sit alone		Bowel trained
	Babble		Dry in daytime
	Belly crawl		Dry at night
	Crawl		Run well
	First tooth		Ride a tricycle
	Show fear of strangers		Hop on one foot
	Drink from cup		Dress self completely
	Pull to stand		Ride a two wheeled bike
	Stand alone		Tie shoes
	Walk with support		Skip

Which of the above were the most difficult for your child or gave you the greatest concern?

GENERAL DEVELOPMENT

Indicate which items are of special concern to you with an asterisk (*).

Yes	*No*	*		*Yes*	*No*	*	
			Restless, trouble sitting still				Awkward, clumsy
			Trouble with balance				Fear of movement: sliding, swinging, spinning
			Upset with change				Constant touching
			Difficulty distinguishing left/right				Hard to understand child's speech

Yes	*No*	*		*Yes*	*No*	*	
			Difficulty dressing, fastening clothes				Difficulty manipulating small objects
			Difficulty writing or coloring				Difficulty copying letters/shapes, reverses
			Clumsy at dinner table				Difficulty using knife, fork, spoon
			Very slow while eating				Difficulty sitting through dinner

Yes	*No*	*	
			Avoids touching specific textures, such as sand, mud, foods, lotions
			Frequently runs into or accidentally bumps into objects or people
			Overly sensitive to sound (puts hands over ears)
			Did your child ever acquire speech and then stop talking?

Yes	*No*	*	
			Does your child have trouble making certain sounds?
			Does your child use speech as conversation, talking with family and friends?
			Do you think your child understands what you say to him/her?
			Can your child follow directions? How many can he/she be given at a time? ____________________

Yes	*No*	*	
			Has your child had a hearing screening? Results:
			Has your child had a vision screening? Results:
			Does your child have a clear hand preference? Right handed? __________ Left handed? __________

Please describe any development items you starred (*) in this space. Please give examples.

CHILD'S EDUCATION

Your child's current school: ____ Grade: ____________________

Address: ____ Phone: ________________________

Name(s) of teacher(s): ____ Principal: ____________________

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Child's academic strengths: ______________________________

Child's academic weaknesses: ______________________________

Child's behavior problems in school: ______________________________

Grades: Above average ________ Average ________ Below Average________

Ability: Above average ________ Average ________ Below Average________

Attendance: Usually present ________ Often absent, with excuse ________ Truant ________

Relation with peers: Excellent ________ Usually gets along ________ Problems________

Please explain: ______________________________

Relation with teacher(s): Excellent ________ Usually gets along ________ Problems________

Please explain: ______________________________

PREVIOUS SCHOOL/DAYCARE

Daycare: ______________________________
Where *Dates*

Preschool: ______________________________
Where *Dates*

Elementary: ______________________________
Where *Dates*

Other: ______________________________
Where *Dates*

Has your child received special help in any of the schools attended (tutoring, Special Ed, therapies)?

______________________________ Yes_____ No_____
Type of help *Dates of Contact* *Beneficial?*

______________________________ Yes_____ No_____
Type of help *Dates of Contact* *Beneficial?*

______________________________ Yes_____ No_____
Type of help *Dates of Contact* *Beneficial?*

Has your child repeated any grades? YES NO If yes, when? ________________

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Do you feel that the school is dealing appropriately with your child's challenges? YES NO

Please explain: ____
____

Is the child presently involved or was he/she previously involved in any extracurricular activities, school related or otherwise? YES NO If yes, please give details and provide successes and/or problems:
____
____
____
____
____

BEHAVORIAL DEVELOPMENT

Which of the following describes your child? (Indicate an asterisk (*) on the left of those which are of special concern to you).

Past	*Present*			*Past*	*Present*		
			Fears				Much fantasy
			Much daydreaming				Self-destructive behavior
			Suicidal thoughts or attempts				Fitful sleeping
			Nightmares				Careless, poor judgment

Past	*Present*			*Past*	*Present*		
			Poor attention or concentration				Difficulty following instructions
			Difficulty solving problems				Poor memory
			Destroys property				Fire setting
			Helps with chores				Goes to time-out easily

Past	*Present*			*Past*	*Present*		
			Verbal aggression				Physical aggression
			Cruelty to animals				Lying
			Drug use				Stealing
			Often sad				Often angry

Past	*Present*			*Past*	*Present*		
			Usually a loner				Prefers adults over children
			Prefers younger children				Prefers older children
			Likes to lead				Likes to follow
			Frequent fights with friends				Frequent fights with family

Past	*Present*			*Past*	*Present*		
			Has few hobbies or interests				Has trouble sleeping
			Has temper tantrums				Runs away
			Uncooperative in stores/restaurants				Has trouble at bedtime
			Has trouble playing by self				Handles money well
			Nervous habits or tics				Can't seem to stop talking

Please describe any items you starred (*) above in this space. Give examples.

Describe your child's strengths (with regards to abilities, behaviors, etc.): ______________________

FAMILY MEDICAL HISTORY AND RELATIONSHIPS

Does anyone in the child's family (include grandparents/aunts/uncles) have any medical issues?

Does anyone in the child's family (include grandparents/aunts/uncles) have any emotional/behavioral issues?

Does your child have particular fears or worries? If so, what are they?

How does your child get along with each parent? ______________________

How does your child get along with sibling(s)? ______________________

What kind of behavior usually requires discipline? ______________________

What does Dad do to discipline? ______________________

What does Mom do to discipline? ______________________

ACTIVITIES: *What kind of things do you do together with your child?*

Father: ______________________

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Mother: ____
____

In what joint activities do you engage as a family? ______________________________
____

SIGNIFICANT EVENTS

Have any of the following ever occurred in your family?

Mo/Yr		*Please describe*
	Move to a new place	
	Birth of a sibling	
	Change of school for child	
	Separation from parent	
	Serious illness/injury in family	
	Death in family	
	Change in living arrangements	
	Change in family's financial status	
	Promotion	
	Loss of job	
	Change of job	
	Parent began working outside home	
	Divorce or marital separation	
	Legal problems	
	Emotional difficulties or problems	
	Other (specify)	

Please give additional details here. What has been your child's reaction to the above significant events?

Is there anything else you would like me to know about family relationships/behavior?