CHILD BACKGROUND QUESTIONNAIRE

Child's name: ______________________________________ Today's date: ____________________

Birth date: __________________________ Last 4 digits of client's Social Security #: _______________

Age: ___________ Gender: _____________ Ethnicity: ______________

Home address: _______________________________________ City:________________ Zip:__________

School: ____ Current Grade: _________

Current Height: ____________ Current Weight: ______________ Handedness: R _____ L ______

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

Other (please explain): ____

Mother's name: _________________________ Age: ______ Education: _______ Occupation: _______________

Father's name: __________________________ Age: _______ Education: _______ Occupation: _______________

Stepparent's name: ______________________ Age: _______ Education: _______ Occupation: _______________

Household Income Range: ____

Marital/Relationship status of biological parents: ____

If parents are no longer together, how old was child at time of separation? ___________

List all people living in household:

Name	Age	Relationship to Child	Describe Relationship

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

Primary language spoken in the home: ____

Other languages spoken in the home: ____

PRESENTING PROBLEMS

Briefly describe your child's current difficulties: ____
____
____
____
____

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

When was the problem first noticed? ____
____
____

What seems to help the problem? ____
____
____

What seems to make the problem worse?____
____
____

Does the problem occur more often in certain settings?____
____
____

Has he/she received evaluation or treatment (i.e., therapy) for the current problem or similar problems? Y___ N____

If yes, when and with whom? ____
____
____

Was treatment effective? Yes ______ No _________

What did you like best about the treatment? ____
____
____

What did you like least about the treatment? ____
____
____

Has your child ever received a mental health diagnosis? Yes ______ No ______
If yes, what diagnoses and when? ____
____

Are you currently taking any medication at this time? Yes ______ No _______
If yes, please note kind of medication below:

____
____
____
____

SOCIAL AND BEHAVIOR CHECKLIST

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

______ Has difficulty with speech

______ Has difficulty with hearing

______ Has difficulty with language

______ Has difficulty with vision

______ Has difficulty with coordination

______ Prefers to be alone

______ Does not get along well with other children

______ Difficulty with social norms

______ Is aggressive

______ Is shy or timid

______ Is more interested in things (objects) than in people

______ Engages in behavior that could be dangerous to self

______ Has special fears, habits, or mannerisms (describe) ____

______ Shows daredevil or risky behavior

______ Gives up easily

______ Wets bed or clothing

______ Expresses frequent worries or concerns

______ Bites nails

______ Sees or hears things that others don't

______ Is constantly irritable and angry

______ Has frequent tantrums

______ Has frequent nightmares

______ Has trouble sleeping (describe)________________

______ Has blank staring spells

______ Rocks back and forth

______ Bangs head

______ Holds breath

______ Poor hygiene

______ Poor diet

______ Is stubborn

______ Has poor bowel control (soils self)

______ Is much too active

______ Is impulsive

______ Fidgets

______ Sucks thumb

______ Is slow to learn

______ Wrings hands

______ Picks at own skin/pulls hair

______ Injures self

______ Has contemplated/attempted suicide

Other (please described): ____
____
____
____

EDUCATIONAL HISTORY

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

______ Difficulty with reading

______ Difficulty with math

______ Difficulty with spelling

______ Difficulty with writing

______ Does not like school

______ Failing classes

______ Difficulty with other subjects (please list)__________________________
____

_____ Poor study habits

_____ Refuses to attend school

_____ Frequent absences

_____ Low motivation

Academic strengths:____
____
____

Has your child been diagnosed with a learning disability? Yes _____ No _____

If yes, please explain. ____
____

Is your child in a special education class? Yes ______ No ______

If yes, what type of class?____

Does your child currently have an Individualized Education Plan (IEP)? Yes _____ No _____

If yes, please provide any details about the IEP that you can. _______________________________________
____

Has your child been held back in a grade? Yes ______ No ______

If yes, what grade and why? ____

Has your child ever received special tutoring or therapy in school? Yes ______ No ______

If yes, please describe.____

What were your child's most recent grades?____
____

Have your child's grades changed (either improved or worsened)? Yes _____ No _______

If yes, please describe. ____
____

History of school referrals: Yes _____ No _____

If yes, please describe. ____
____

DEVELOPMENTAL HISTORY

During pregnancy, was mother on medication? Yes_____ No ______If yes, what kind? ________________________

During pregnancy, did mother smoke? Yes ______ No ______ If yes, how many cigarettes each day? ___________

During pregnancy, did mother drink alcoholic beverages? Yes ______ No ______ If yes, what did she drink? _____

Approximately how much alcohol was consumed each day?____

During pregnancy, did mother use drugs? Yes ______ No ______ If yes, what kind? __________________________

Was a Cesarean section performed? Yes ______ No ______ If yes, for what reason? __________________________

Was the child premature? Yes ______ No ______ If so, by how many months? ______________________________

What was the child's birth weight? ________________

Were there any birth defects or 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. ___________________________

As an infant, did the child cry excessively? Yes ______ No ______

If yes, describe. ____

As an infant, was the child hard to comfort? Yes _____ No _____

As an infant, did the child like to be held? Yes ______ No ______

As an infant, was the child alert? Yes ______ No ______

As a baby, did the child demonstrate a range of emotions? Yes _____ No _____

Were there any special problems in the growth and development of the child during the first few years?
Yes ____ No____

If yes, please describe. ____

As a toddler, did your child seek you out to share in play and enjoyment? Yes ____ No ______

The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. Please estimate as best as possible when unsure.

Behavior	Age	Behavior	Age
Showed response to parent	______	Spoke first word	______
Rolled over	______	Put several words together	______
Sat alone	______	Dressed self	______
Crawled	______	Became toilet trained	______
Walked alone	______	Stayed dry at night	______
Babbled	______	Fed self	______

CHILD'S MEDICAL HISTORY

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.

	Illness or condition	Date(s) or Age(s)		Illness or condition	Date(s) or Age(s)
_____	Measles	______________	_____	Dizziness	______________
_____	Mumps	______________	_____	Difficulty concentrating	______________
_____	Chicken Pox	______________	_____	Memory problems	______________
_____	Whooping cough	______________	_____	Extreme tiredness or Weakness	______________
_____	Meningitis	______________	_____	Epilepsy	______________
_____	Encephalitis	______________	_____	Convulsions	______________
_____	High fever	______________	_____	Seizures	______________
_____	Allergy	______________	_____	Frequent/Severe headaches	______________
_____	Injuries to head	______________	_____	Diabetes	______________
_____	Broken bones	______________	_____	Cancer	______________
_____	Hospitalizations	______________	_____	High blood pressure	______________
_____	Operations Describe: _____________________________	______________	_____	Heart disease	______________
_____	Asthma	______________	_____	Paralysis	______________
_____	Fainting Spells	______________	_____	Loss of consciousness	______________
_____	Other: _______________________________				

FAMILY MEDICAL HISTORY

Place a check next to any illness or condition that any member of the child's family has had.

	Condition	Relationship to child		Condition	Relationship to child
_____	Alcoholism	__________________	_____	Depression	____________________
_____	Schizophrenia	__________________	_____	Learning disability	___________________
_____	Bipolar Disorder	__________________	_____	ADHD	____________________
_____	Anxiety Disorder	__________________	_____	Intellectual Disability	_________________

Other/Additional Information: ____
____
____

DISCIPLINE TECHNIQUES

Place a check next to each discipline technique that you typically use when your child behaves inappropriately?

	Disciplinary technique		Disciplinary technique
_____	Ignore problem behavior	_____	Time Out
_____	Scold child	_____	Send child to his or her room
_____	Spank child	_____	Take away something
_____	Threaten child	_____	Other technique (describe) ____________________
_____	Reason with child		____________________________
_____	No techniques used	_____	Redirect child's interest

Which disciplinary techniques are usually effective? ____
____

With what type of problem(s)? ____
____

Which disciplinary techniques are usually ineffective? ____
____

With what type of problem(s)? ____
____

What types of discipline techniques were used by your parents? ________________________________
____
____

POSITIVE REINFORCEMENT

Have you ever used rewards or incentives with your child? Yes _____ No ______

If yes, what rewards or incentives have you used? ____
____
____

What rewards/incentives have been effective? ____
____
____

What has not been effective with using rewards/incentives with your child? __________________________
____
____

What behaviors have you targeted with rewards/incentives? _____________________________________
____
____

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 would *you* like your child to engage in more often than he/she does currently?

1. ________________________ 2. ______________________________ 3. ______________________

What activities does your child like least?

1.__________________________ 2.________________________________ 3.______________________

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

If yes, please describe briefly. ____
____
____

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

What are your child's assets or strengths?
____
____
____
____

Is there any other information you would like to share about your child?
____
____
____
____
____

Please provide any additional questions or concerns below:
____
____
____
____
____
____