BACKGROUND QUESTIONNAIRE - CHILD

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 FAMILY

Child's Name_____ Today's Date_____

Birthdate_____Age_____Grade_____Name of School_____

Birth Country_____Age on arrival in country if born elsewhere_____

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

Cellphone #:_____

Biological Mother's Name_____ Age_____ Highest Grade Completed_____

Number of Years of Education:_____ Degree/Diploma (if applicable)_____

Occupation:_____

Biological Father's Name_____ Age_____ Highest Grade Completed_____

Number of Years of Education:_____ Degree/Diploma (if applicable)_____

Occupation:_____

Marital status of biological parents: (circle one) Married Separated Divorced Widowed Other

If biological parents are separated or divorced:

How old was this child when the separation occurred?_____

Who has legal custody of the child? (circle one) Mother Father Joint/Both Other

Stepparent's Name:_____ Age_____ Occupation_____

If this child is not living with either biological parent:

Reason:_____

(circle one) Adoptive parents Foster parents family members Group home Other

Name(s) of legal guardian(s):_____

BACKGROUND QUESTIONNAIRE - CHILD

Confidential

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:

_____

_____

Primary language spoken in the home:_____

Other languages spoken in the home:_____

If your child's first language is not English, please complete the following:

Child's first language_____ Age at which your child learned English:____

CURRENT MEDICATIONS

List all medications that your child is currently taking:

Medication	Reason taken	Dosage (if known)	Start date

BEHAVIOR CHECKLIST

Place a check mark next to behaviors that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his or her age.

Sleeping and Eating

☐ Nightmares

☐ Trouble sleeping

☐ Eats poorly

☐ Eats excessively

☐ Dangerous to self or others (describe):

_____
_____

BACKGROUND QUESTIONNAIRE - CHILD

Confidential

Social Development

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

Behavior

- ☐ Stubborn
- ☐ Irritable, angry or resentful
- ☐ Frequent tantrums
- ☐ Strikes out at 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)

- ☐ Purposely harms or injures self (describe):

  _____
  _____

- ☐ Talks about killing self (describe):

  _____
  _____

- ☐ Unusual fears, habits or mannerisms (describe):

  _____
  _____

- ☐ 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

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

BACKGROUND QUESTIONNAIRE - CHILD

Confidential

☐ Poor sense of danger

☐ Skips school

☐ Problems with taste and smell

Motor Skills

☐ Poor fine motor coordination

☐ Poor gross motor coordination

OTHER PROBLEMS:

_____
_____
_____
_____

EDUCATION PROGRAM

Does your child have a modified learning program? (circle one) Yes No

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

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

_____
_____
_____

Has your child been held back a grade? (circle one) Yes No

Is your child in any special education classes? (circle one) Yes No

If yes, please describe:_____

_____

Is your child receiving learning assistance at school? (circle one) Yes No

If yes, please describe:_____

_____

Has your child been suspended or expelled from school? (circle one) Yes No

If yes, please describe:_____

_____

Has your child ever received tutoring? (circle one) Yes No

If yes, please describe:_____

_____

Briefly describe classroom or school problems if applicable:_____

_____
_____

BACKGROUND QUESTIONNAIRE - CHILD

Confidential

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
- ☐ Easily distracted
- ☐ Frequently forgets instructions
- ☐ Frequently loses belongings
- ☐ Difficulty planning tasks
- ☐ Doesn't foresee consequences of actions
- ☐ Slow thinking
- ☐ Difficulty with math/handling money
- ☐ Poor understanding of time

Describe briefly any other cognitive problems that your child may have:_____

_____

Describe any special skills or abilities that your child may have:_____

_____

BACKGROUND QUESTIONNAIRE - CHILD

Confidential

DEVELOPMENTAL HISTORY

If your child is adopted, please fill in as much of the following information as you are aware of.

During pregnancy, did the mother of this child:

Take any medication? (circle one) Yes No

If yes, what kind?_____

Smoke? (circle one) Yes No

If yes, how many cigarettes each day?_____

Drink alcoholic beverages? (circle one) Yes No

If yes, what kind?_____

Use drugs? (circle one) 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):_____ Apgars :_____ / _____

Were there any indications of fetal distress? (circle one) Yes No

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

Circle any that apply to the birth: Labor induced Forceps Breech Cesarean

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

What was your child's birth weight?_____

Circle any that apply following birth: Jaundice Breathing problems Incubator Birth defect

If any, please describe:_____

Were there any other complications? (circle one) Yes No

If yes, please describe:_____

BACKGROUND QUESTIONNAIRE - CHILD

Confidential

Were there any feeding problems? (circle one) Yes No

If yes, please describe:_____

Were there any sleeping problems? (circle one) Yes No

If yes, please describe:_____

Were there any growth or developmental problems during the first few years of life? (circle one) 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?

(circle all that apply):

Unusually quiet or inactive	Colic	Headbanging
Did not like to be held or cuddled	Excessive restlessness	Constantly into everything
Not alert	Excessive sleep	Excessive number of accidents
Difficult to soothe	Diminished sleep	compared with other children

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

	Early	Average	Late	Never		Early	Average	Late	Never
Smiled					Tied shoelaces				
Rolled over					Dressed self				
Sat alone					Fed self				
Crawled					Bladder trained, day				
Walked					Bladder trained, night				
Ran					Bowel trained				
Babbled					Rode tricycle				
First word					Rode bicycle				
Sentences									

MEDICAL HISTORY

Vision problems (circle one) No Yes (describe:_____) Date of last vision exam: _____

Hearing problems (circle one) No Yes (describe:_____) Date of last hearing exam:_____

BACKGROUND QUESTIONNAIRE - CHILD

Confidential

Provide the approximate date or age next to any illness or condition that your child has had:

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	
Whooping cough		Tuberculosis	
Diphtheria		Bone or joint disease	
Scarlet fever		Sexually transmitted disease	
Meningitis		Anemia	
Pneumonia		Jaundice/hepatitis	
Encephalitis		Diabetes	
High fever		Cancer	
Seizures		High blood pressure	
Allergy		Heart disease	
Hay fever		Asthma	
Injuries to head		Bleeding problems	
Broken bones		Eczema or hives	
Hospitalizations		Physical abuse	
Operations		Sexual abuse	
Ear infections		Other:_____	
Paralysis			

FAMILY MEDICAL HISTORY

Provide the family member's relationship to the child for any illness or condition that any member of the immediate family (i.e., brother, sister, aunt, uncle, cousin, grandparent) has had:

Condition	Relationship to child	Condition	Relationship to child
Seizures or epilepsy		Tics or Tourette's syndrome	
Attention deficit		Alcohol abuse	
Hyperactivity		Drug abuse	
Learning disabilities		Suicide attempt	
Mental retardation		Physical abuse	
Childhood behavior problems		Sexual abuse	
Mental illness		Neurological illness or disease	
Depression or anxiety		Antisocial behavior (assaults, thefts, etc.)	

BACKGROUND QUESTIONNAIRE - CHILD

Confidential

List any previous assessments that your child has had:

Assessment	Dates of testing	Name of examiner
Psychiatric		
Psychological		
Neuropsychological		
Educational		
Speech pathology		

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

Type of treatment Dates Name of therapist

_____

_____

_____

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? (circle one) Yes No

If yes, please describe briefly:_____

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

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 that you think may help me in assessing your child?_____

_____