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CHILD HISTORY QUESTIONNAIRE

CONFIDENTIAL

The purpose of the questionnaire is to obtain background data concerning your child. By completing this confidential form as fully as possible, you are assisting our staff with this evaluation and helping to ensure all information is clarified. If you wish to add any additional comments, please do so on the last sheet.

Date: _____ Child's Name: _____ Date of Birth: _____ Age____
Address:_____ City _____ State _____
Zip_____How long has child lived at this address? _____
Birthplace:_____
Child's Pediatrician: _____ Phone #: _____
Person completing this form: _____
Relationship to Child: _____

REFERRAL INFORMATION: Who referred you to our practice?
Name: _____ Phone #: _____

PRIMARY CONCERNS: Please describe the problem(s) or concerns for which you are seeking help at this time:

_____
_____
_____
When did the problem(s) first appear or begin? _____

Whom else have you consulted about your child's problem(s)?

_____
What procedures have you tried on your own?

_____

Has your child ever received any of the following diagnoses? Check box to the left if "YES."

	Anxiety Disorder		Developmental Delay
	Attention Deficit/Hyperactivity Disorder		Disruptive Behavior Disorder

	Autism Spectrum Disorder		Feeding Disorder
	Cognitive Disability (MR)		Learning Disability
	Conduct Disorder		Seizure Disorder
	Depression		Tic Disorder

Other/Comments:

_____

Does your child demonstrate any of the following behaviors? Check box to the left if "YES."

	Impulsivity, lack of self-control		Daytime toileting accidents
	Hyperactivity		Bedtime toileting accidents
	Attention problems		Inappropriate sexual behavior
	Tantrums		Self-injurious behaviors
	Aggressive behavior (i.e. hitting, kicking, biting)		Motor tics
	Verbal abuse (i.e. swearing)		Verbal tics
	Noncompliance at home		Running away/Elopement
	Noncompliance at school		Stealing
	Overreacting to situations (i.e. cries easily, short temper)		Lying

Other/Comments:_____

Does your child demonstrate any of the following problems in school? Check box to the left if "YES."

	Does not complete homework		Poor Handwriting
	Forgets assignments/ materials		Poor Reading Skills
	Incomplete classroom work		Poor Math Skills
	Makes many careless errors		Poor Writing Skills
	Excessive time to complete assignments		Poor Spelling
	Failure to follow directions		Messy and Disorganized
	Talks our inappropriately		Does not remain seated
	Poor attention in class		Does not get along with peers

Other/Comments:_____

PRIOR TESTING

Has your child received prior psychological or educational testing? Yes ___ No ___ Name of examiner: _____ Date of testing: _____

Please bring in a copy of the report.

PRIOR TREATMENT	Name	Date Started	Date Ended
Occupational Therapy			
Physical Therapy			
Speech Therapy			

Psychiatrist			
Counseling			
Academic Tutoring			

CHILD'S MEDICAL HISTORY
Prenatal:
Did Child's mother receive regular prenatal care during her pregnancy? Yes __ No __

Mother's age at time of birth? _____ years Father's age at time of birth? ___ years

Did mother smoke during pregnancy? Yes ___ No___ Drink alcohol? Yes___ No ___

Was this a planned pregnancy? Yes__ No __ Which pregnancy for mother (1st, 2nd, etc.) __
Did the mother suffer from any illnesses/complications during pregnancy?
Yes __ No __

If Yes, please explain:

_____
_____

BIRTH HISTORY:
Child's birth weight: _____lbs. _____oz. Length: _____ inches
How many weeks gestation? _____ How long did labor last? _____ Please list any problems related to child's birth:

_____
_____

DEVELOPMENTAL HISTORY
At what age did your child: sit alone _____ walk alone _____ say first word _____ speak in sentences _____ become toilet trained _____ dress self _____

Compared to other children, did or does your child have difficulty with any of the following? Check box to the left if "YES."

	Learning to Talk		Sitting still for stories or TV
	Understanding Language		Playing/socializing with other children
	Gross Motor skills (walking, hopping, running)		Building with blocks, doing puzzles
	Fine Motor skills (drawing, buttoning, tying)		Separating from parents
	Early academic skills (naming colors, numbers)		Sleeping
	Showing a clear hand preference (Which hand is preferred? _____)		Eating

If you responded "YES" to any of the above, please describe:
_____ Please check if your child has ever had any of the following:

	Febrile Seizures		Concussion/Head Injury

	Epilepsy		Eating Difficulties
	Lead Poisoning		Sleeping Difficulties
	Exposure to Toxins		Surgery (please describe below)
	Frequent Ear Infections		
	Asthma/Allergies		

Any other health concerns:

_____
_____

Please check all that help to describe your child's temperament:

	Shy/Timid		Stubborn
	Affectionate		Temperamental/Moody
	Dare Devil/Bold		Fearful
	Cautious		Overactive
	Underactive		Happy
	Easy to Manage		Curious
	Aggressive		Slow to warm up

Describe your child's strengths:

_____
_____

What does your child enjoy doing the most?

_____
_____

MEDICATION HISTORY

Has your child ever taken psychiatric medications? Yes _____ No _____
If Yes: Name of Medication: _____ Prescribed By:_____ For treatment of: _____

SCHOOL INFORMATION:

Name of current school: _____ Phone _____
Teacher's name: _____ Grade: _____
List previous schools, dates attended and indicate overall performance, academic and behavioral:
Name of school: _____ Dates:_____
Comments:

_____
_____ Name of school: _____ Dates:_____ Comments:
_____
_____

Is your child in any special programs (speech, reading, etc.)? If yes, explain:

_____ What does your child do best in at school?

_____
_____

Has your child ever repeated a grade (including preschool)? If yes, explain:
_____
_____

FAMILY INFORMATION:
Father's Name: _____ Age: _____ Education:_____
Employment: _____

Mother's Name: _____ Age: _____ Education:_____
Employment: _____

Child's parents are currently: Married _____ Divorced _____ Separated _____ Is your child adopted? Yes _____ No _____ List other siblings (names and ages) in the home:
_____

FAMILY PSYCHOLOGICAL HISTORY:
Has Child's FATHER or FATHER's relatives had emotional or learning problems; for example, ADHD, depression or anxiety? Yes_____ No_____
Has Child's MOTHER or MOTHER's relatives had emotional or learning problems?
Yes_____ No_____
Has Child's BROTHER(s) or SISTER(s) had emotional or learning problems?
Yes_____ No_____

If yes, please describe, including treatment and other providers that your family has worked with in the past. _____
_____
_____
_____

FAMILY MEDICAL HISTORY:
Is there any family history of medical illnesses (e.g., seizures, thyroid problems, allergies)? Yes_____ No_____ If yes, please describe
_____

ADDITIONAL INFORMATION:

Is there anything else you feel we should know about your child?
_____
_____
_____

Signature: _____ Date: _____