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

CHILD/ADOLESCENT BACKGROUND QUESTIONNAIRE

FAMILY DATA

Name: _____ Today's date: _____

Address: _____ Apt. #: _____

_____ Zip Code: _____

School/Employment: _____ Birthday: _____

Age: _____ Grade: _____ Sex: _____ Home Phone#: _____

Mother's Name: _____ Occupation/Education: _____

Address: _____ Cell Phone #: _____ Work Phone#: _____

Father's Name: _____ Occupation/Education: _____

Address: _____ Cell Phone#: _____ Work Phone#: _____

Marital Status of Parents: _____ Stepparents: _____

If parents are separated or divorced, how old was the child when separation occurred? _____

List all people living in your household:

NAME	RELATIONSHIP TO CHILD	AGE

If any brothers or sisters live outside the home, list their names and ages:

NAME	AGE	EDUCATION	OCCUPATION

Primary language spoken in the home: _____

Other languages spoken in the home: _____

PRESENTING PROBLEM

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? _____

_____

Has the child received evaluation or treatment for the current (or similar) problems? Yes _____ No _____

If yes, when and with whom? _____

Is the child on any medication at this time? Yes _____ No _____

If yes, what kind and on what schedule: _____

_____

(PLEASE REMEMBER TO BRING MEDICATIONS IF YOUR CHILD WILL NEED THEM DURING THE EVALUATION.)

EDUCATIONAL HISTORY

List schools attended:

NAME	LOCATION	GRADE

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

_____ Difficulty with reading

_____ Difficulty with arithmetic

_____ Difficulty with spelling

_____ Difficulty with writing

_____ Difficulty with other subjects (please specify) _____

Does your child enjoy school? Yes _____ No _____

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

If yes, what type of class? _____

Has your child been held back a grade? Yes _____ No _____

If yes, which grade and why? _____

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

If yes, please describe: _____

_____

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	_____
_____ GERMAN MEASLES	_____	_____ FREQUENT OR SEVERE HEADACHES	
_____ MUMPS	_____		_____
_____ CHICKEN POX	_____	_____ BACK PAIN	_____
_____ VISUAL PROBLEMS	_____	_____ DIFFICULTY CONCENTRATING	
_____ MENINGITIS	_____	_____ MEMORY PROBLEMS	_____
_____ ENCEPHALITIS	_____	_____ EXTREME TIREDNESS, WEAKNESS	
_____ FEVER OF UNKNOWN ORIGIN		OR FATIGUE	_____
	_____	_____ RHEUMATIC FEVER	_____
_____ CONVULSIONS	_____	_____ EPILEPSY	_____
_____ ALLERGIES	_____	_____ TUBERCULOSIS	_____
(ALLERGIES TO WHAT?)	_____	_____ BONE OR JOINT DISEASE	
_____			_____
_____ INJURIES TO HEAD	_____	_____ ANEMIA	_____
_____ LOSS OF CONSCIOUSNESS		_____ JAUNDICE/HEPATITIS	_____
	_____	_____ DIABETES	_____
_____ BROKEN BONES	_____	_____ CANCER	_____
(WHICH BONES?)	_____	(WHAT TYPE?)	_____
_____		_____	
_____ HOSPITALIZATIONS	_____	_____ HIGH BLOOD PRESSURE	_____
(FOR WHAT REASON?)	_____	_____ HEART DISEASE	_____
_____		_____ ASTHMA	_____
_____ SURGERIES	_____	_____ BLEEDING PROBLEMS	_____
(WHAT KIND?)	_____	_____ ECZEMA OR HIVES	_____

MEDICAL HISTORY (CONTINUED)

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)
_____ EAR PROBLEMS	_____	_____ DEPRESSION	_____
_____ MIGRAINES	_____	_____ SUICIDE ATTEMPTS	_____
_____ FAINTING SPELLS	_____	_____ STOMACH PROBLEMS	_____
_____ OTHER	_____	_____ OBESITY	_____
(SPECIFY) _____		_____ PARALYSIS	_____

DEVELOPMENTAL HISTORY

During pregnancy, was mother on medications? Yes _____ No _____

If yes, what kind? _____

During pregnancy, did mother smoke? Yes _____ No _____

If yes, how much? _____

During pregnancy, did mother drink alcoholic beverages? Yes _____ No _____

If yes, what kind and how much? _____

During pregnancy, did mother use drugs? Yes _____ No _____

If yes, what kind? _____

Were there any complications related to pregnancy and/or birth? (examples: early bleeding, preeclampsia, long labor, forceps delivery, emergency Caesarian, etc.) _____

_____

Was child premature? Yes _____ No _____ If so, by how much? _____

What was the child's approximate birth weight? _____

Were there any medical problems during early infancy? _____

Were there any problems in early development? (examples: walked late, delayed speech, failure to thrive, etc.)

_____

Any early eating or sleep problems? Yes _____ No _____ If yes, what? _____

_____

On the next page is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't know the age at which the behavior occurred, please write a question mark:

BEHAVIOR	AGE	BEHAVIOR	AGE
Showed response to mother	_____	Put several words together	_____
Rolled over	_____	Dressed self	_____
Sat alone	_____	Became toilet trained	_____
Crawled	_____	Stayed dry at night	_____
Walked Alone	_____	Fed self	_____
Babbled	_____	Rode tricycle	_____
Spoke first word	_____		

FAMILY MEDICAL HISTORY

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

CHECK	CONDITION	RELATIONSHIP TO YOUR CHILD
_____	ALCOHOLISM	_____
_____	CANCER	_____
_____	DIABETES	_____
_____	HEART TROUBLE	_____
_____	LEARNING PROBLEMS	_____
_____	NERVOUS OR PSYCHOLOGICAL PROBLEMS	_____
_____	DEPRESSION	_____
_____	SUICIDE ATTEMPT	_____
_____	OTHER (DESCRIBE:)	_____

SOCIAL AND BEHAVIOR CHECKLIST

Place a check by any behavior or problem the child currently has or has had in the past:

	(Check)	Age(s) when first exhibited
Difficulty with speech	_____	_____
Difficulty with hearing	_____	_____
Difficulty with understanding language	_____	_____
Difficulty with verbal expression	_____	_____
Difficulty with vision	_____	_____
Difficulty with gross motor coordination (i.e., running)	_____	_____
Difficulty with fine motor coordination (i.e., writing, buttoning,etc.)	_____	_____

SOCIAL AND BEHAVIOR CHECKLIST (CONTINUED)

Place a check by any behavior or problem the child currently has or has had in the past:

	(Check)	Age(s) when first exhibited
More interested in things (objects) than in people	_____	_____
Engages in behavior that could be dangerous to self or others (Describe:)_____	_____	_____
Has special habits or mannerisms (Describe:) _____	_____	_____
Rocks head back or forth	_____	_____
Bangs head	_____	_____
Holds breath	_____	_____
Gives up easily	_____	_____
Nailbiting	_____	_____
Too fearful or anxious	_____	_____
Quick temper	_____	_____
Frequent nightmares	_____	_____
Difficulty sleeping (describe:) _____	_____	_____
Difficulty concentrating	_____	_____
Difficulty completing tasks	_____	_____
Poorly organized	_____	_____
Poor eating habits	_____	_____
Stubbornness	_____	_____
Frequently sad or unhappy	_____	_____
Excessively active	_____	_____
Clumsiness	_____	_____
Impulsivity	_____	_____
Sudden changes in mood or feeling	_____	_____
Slowness to learn	_____	_____
Other (describe:) _____	_____	_____

_____

OTHER INFORMATION

What are your child's favorite activities? _____

_____

What activities would your child like to engage in more often? _____

_____

What activities does your child like least? _____

_____

Describe you child's interactions with peers: _____

_____

_____

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? Place a check next to each technique that you usually use. There is also space for writing in any other disciplinary techniques that you use.

CHECK	DISCIPLINE TECHNIQUE	CHECK	DISCIPLINE TECHNIQUE
_____	Ignore problem behavior	_____	Tell child to sit on chair
_____	Scold child	_____	Send child to his or her room
_____	Spank child	_____	Take away some activity or food
_____	Threaten child	_____	Reason with child
_____	Redirect child's interest	_____	Don't use any technique
_____	Other? _____		

_____

Which disciplinary technique(s) are usually effective? _____

_____

With what type of problem? _____

Which disciplinary technique(s) are usually ineffective? _____

_____

With what type of problem? _____

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

_____

Have you ever sought help from a mental health professional regarding your child's behavior or emotional adjustment? Yes _____ No _____ If yes, please give the name of the service provider, age when treatment began, and the duration: _____

What are your child's assets or strengths? _____

_____

Is there any other information that you think may help in working with your child? _____

_____

Please attach copies of relevant medical, psychological, or educational reports. Thank you.