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Child History Questionnaire

Please complete the following questionnaire to give me a general understanding of various aspects of your child's life. This information will be very helpful in determining the types of intervention that your child may need.

Child's name: _____ Birth date: _____Age:_____

Name of the parent/guardian: _____

Home Address: _____

City: _____ State:_____ Zip Code:_____ Today's date:_____

Home Phone: ( ) ____- _____Cell Phone: ( ) ____- _____ e-mail:_____

Is it OK to receive email regarding appointments yes/no

it OK to leave a voicemail at home____ mobile____ work____ yes/no

Emergency Contact's name: _____ Phone: ( ) ____- _____

Person completing this form: _____ Relationship to child: _____

Child's Birthplace: _____ Religious affiliation:_____ Pronouns: she/her he/him they/them
Current School:_____ Current Grade: _____

What are the problems that caused you to seek help for your child?

_____
_____

List three issues/conditions that concern you most:

- _____
- _____
- _____

When did you first notice these issues/conditions?

_____
_____

What worries you most if things stay the way they are?

_____
_____

Please list any medications that your child is taking at this time (including vitamins, natural products, etc.)

_____
_____

Who referred you to me? _____ Can we thank them? □ Yes □ No

Family History:

1. Child is living with: □ Both parents □ Mother □ Father □ Grandparent(s) □Step-Parent □ Legal Gaurdian □ Other: _____

1. Is the child adopted: □ Yes □ No Child's age at adoption: _____ Country:_____

2. Status of parents' relationship:

□ Married □ Separated □ Divorced □ Widowed □ Never Married
How long married? _____ How long divorced? _____ Child's age at divorce:____

If divorced:
Legal Custody: 50/50 □ yes □ no If no, primary legal parent_____
Physical Custody (please fill out percentage): Parent 1_____ Parent 2_____
Current Child Sharing Arrangement (how is child's time divided):_____
_____

4. Parent 1 Name: _____ Age:_____ Work phone: _____
Cell phone:_____ Email:_____
Employment status: □ employed □ retired □ disabled □ student □ homemaker □ unemployed
When employed, what type of work does Parent 1 do?_____
Current employer is:_____ Education: _____

Parent 2 Name: _____ Age:_____
Cell phone:_____ Email:_____
Employment status: □ employed □ retired □ disabled □ student □ homemaker □ unemployed
When employed, what type of work does Parent 2 do?_____
Current employer is:_____ Education: _____

5. Step-parent 1 Name: _____ Age:_____
Cell phone:_____ Email:_____
Employment status: □ employed □ retired □ disabled □ student □ homemaker □ unemployed
When employed, what type of work does Step-Parent 1 do?_____
Current employer is:_____ Education: _____

Step-parent 2 Name: _____ Age:_____
Cell phone:_____ Email:_____
Employment status: □ employed □ retired □ disabled □ student □ homemaker □ unemployed
When employed, what type of work does Step-Parent 2 do: _____
Current employer is:_____ Education: _____

6. List the people who live at home:

Name:	Age:	Relationship to child:	Occupation:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Please provide any other information about the child's extended family that might help us understand the child's needs (e.g., medical, developmental, behavioral, educational, emotional, or psychological):

_____
_____
_____

Educational History:

Current grade: _____ Name of School: _____
Phone Number: _____

Teacher's Name: _____
Type of school: □ Public □ Private □ Special
How does the school describe your child's classroom behavior?_____
_____
_____

What does your child do best at school? _____
_____

Extracurricular Activities:

Current:	Past (if different):
_____	_____
_____	_____
_____	_____

Do you feel your child is learning up to his or her potential? □Yes □ No
If no, please indicate the academics areas that are underdeveloped:

□ Mathematics: □ Problems with acquisition of mathematical facts
□ Difficulty performing simple arithmetic (e.g., addition, subtraction, division)
□ Difficulty understanding word-problems □ Other: _____

□ Reading: □ Difficulty matching letter sounds to written symbols □ Careless errors
□ Difficulty pronouncing words (especially long ones) □ Reading is "choppy" or non-fluent
□ Difficulty with reading comprehension □ Other_____

My child's experience of reading: □ loves □ likes □ doesn't enjoy □ hates

□ Writing: □ Poor pencil grip □ letters too big □ Inconsistent spacing / inconsistent handwriting □ poor spelling
□ Difficulty expressing ideas in writing
□ When asked to write, does minimum work required, no more than that.

□ Language: □ difficulty finding words to name objects □ takes a long time to get a thought across
□ difficulties understanding or following directions even when paying attention
□ Other: _____

Please check any other concerns or problem your child has in school:

□ Does not do homework	□ Excessive time to complete assignments	□ Distracted
□ Poor handwriting	□ forget assignments	□ Test Anxiety
□ Does not remain seated	□ Starts but does not finish homework	□ Noncompliant in class
□ Incomplete classroom work	□ Excessive talking	□ fails to check homework
□ Messy/disorganized	□ Poor attention in class	□ Makes careless errors

Has your child been retained a grade? □ Yes □ No. If yes, which grade? _____

Did the child attend preschool or daycare? □ Yes □ No

Name_____ □ preschool □ daycare

Name_____ □ preschool □ daycare

Were there any concerns regarding learning or behavior? □ Yes □ No

If yes, what?_____

Has the child been placed in special education programs currently or in the past? □ Yes □ No

If so, what services/program and when? _____

_____

Does your child have:

1. Learning disability (LD): □ Yes □ No. Subjects:_____

2. Language disorder: □ Yes □ No. Type:_____

If yes, who diagnosed the Learning Disabilities?_____

Tutoring: □ Yes □ No. Where: □ School □ Other: _____

Does your child currently have a: □ IEP □ 504 □ Other Health Impaired (OHI) services

Birth and Developmental History:

Pregnancy:

Length of pregnancy: _____ Illness or complications while pregnant? □ Yes □ No

If yes, please explain: _____

Medications used **during** the pregnancy: _____

Substances used **during** the pregnancy: □ Cigarettes How many? ___ How often? (day/week): _____

□ Alcohol How many drinks? ____ How often?(day/week/month):_____

□ Drugs Please describe type and frequency of use: _____

Labor and Delivery:

Was your child's birth normal? □ Yes □ No

Were there any concerns at birth related to lack of oxygen (e.g., born "blue"?): □ Yes □ No

If so, what?_____

Perinatal History:

Birth weight: _____ Length: _____

Did mother or baby stay in Special or Intensive Care? □ Yes □ No

Please describe any problems: _____

Infancy and Early Childhood:
Please rate your child as an infant on the following behaviors. Circle 1 if the behavior on the left was present the majority of the time. Circle 5 if the behavior on the right was present the majority of the time. Stages in between are represented by 2, 3, and 4.

Quiet and content	1	2	3	4	5	Colicky and irritable
Very easy to feed	1	2	3	4	5	Daily feeding problems
Slept well	1	2	3	4	5	Frequent sleeping problems
Usually relaxed	1	2	3	4	5	Often restless
Underactive	1	2	3	4	5	Overactive
Cuddly, easy to hold	1	2	3	4	5	Did not enjoy cuddling
Easily calmed down	1	2	3	4	5	□ Tantrums □ head-banging
Cautious and careful	1	2	3	4	5	□ Accident Prone □ Daredevil
Coordinated	1	2	3	4	5	Uncoordinated
Enjoyed eye contact	1	2	3	4	5	Avoided eye contact
Liked people	1	2	3	4	5	Disliked contact with other people

Please list any other problems or comments regarding infancy or early childhood development:_____
_____
_____

Did any event, health condition, separation, etc., disturb early infant/mother bonding or the developing toddler/mother relationship? □ Yes □ No If yes, please explain: _____
_____
_____

Did any event, health condition, separation, etc., disturb early infant/father or other parent bonding or the developing toddler/father or other parent relationship? □ Yes □ No If yes, please explain _____

Please list the ages your child met these developmental milestones or denote E-early, N-normal or L-late:

Sat on own: _____ Stood up holding onto furniture: _____ Walked alone: _____

Any concerns with your child's *gross* motor development (e.g., running, skipping, jumping): _____
_____

Fed self with spoon: _____ scribbled: _____ tied shoes: _____

Any concerns with your child's *fine* motor development (e.g., writing, buttoning, zipping): _____
_____

Used single words: _____ Used 2+ word-sentences: _____ described a thought: _____

Any speech hearing or language difficulties? □ Yes □ No
Has your child received speech therapy? □ Yes □ No If so, what age?_____

Age Potty trained/day: _____ Age Potty trained/night: _____

Overall rate of development as compared to peers: □ Slow □ Normal □ Fast

Medical History:

Pediatrician's Name: _____ Phone Number: _____
Has the child been taken to the emergency room with a serious emergency, hospitalized, or had outpatient surgery since birth? □ Yes □ No
If yes, please describe condition/injury, treatment, any surgery, how long, and where.

_____
_____
Has your child had a head injury? □ Yes □ No If yes, how many?_____ Did they lose consciousness? □ Yes □ No
How did it happen?_____

Has your child been diagnosed with a chronic health condition? □ Yes □ No If so, what age?_____
If yes, please describe: _____
Does your child take any medication on a regular basis? □ Yes □ No
If yes, please list the name and dosage: _____
_____

Behavioral and Mental Health History:

1. Please describe any behaviors that are particularly concerning to you or others: _____
   _____
   _____
   _____
2. Please list any unusual, traumatic, or possibly stressful events in the child's life that you think may have had an impact on his or her development and current functioning. Include incident, child' age at the time, and comments.
   _____
   _____
   _____
3. Has your child experienced any of the following:
   □ death of a family member? □ parent □ grandparent □ sibling □ other_____
   □ death of a friend □ loss of a pet(s)_____
   □ move (what age/grade)_____
   □ move of close/best friend (age/grade)_____
   □ sleep problems □ nightmares □ eating issues
   □ frequent headaches □ stomachaches □ frequent illnesses
   □ fire setting □ torturing animals
4. Has the child or family received any professional mental health treatment, such as individual or family counseling, group counseling, etc.? □ Yes □ No

If yes, please give the name of previous therapist: _____
May I contact this provider? □ Yes □ No. If yes, please provide phone number: _____

5. Please circle all traits that apply to the child NOW:

impulsive	worrier	aggressive	angry
shyness	distractable	irritable	argumentative
cries easily	fears making mistakes		manipulative

6. Interactions with peers: □ No friends □ Few Friends □ Too shy or too timid □ Loses friends
   □ Risky behaviors □ Bossy, controlling □ Trouble making new friends □ Mean, aggressive

Has your child experienced any of the following:
□ Being teased or bullied □ Teasing/bullying others □ Peer rejection □ Popularity with peers

7. Has your child or any of your family members struggled with any of the following problems? Place checkmark in all that apply:

Condition	Child Current	Child Past	Mother	Father	Sibling	Other
Depression, sadness						
Anxiety, Excessive worries						
Panic Attacks						
Obsessions/Compulsions						
Tics: vocal / motor						
Headaches						
Suicidal Thoughts						
Attempted Suicide						
Learning Disability						
ADHD						
Problems with anger						
Problems with Assertiveness						
Opposition or Defiance						
Problems with the Law						
Schizophrenia/Psychosis						
Nervous Breakdown						
Heavy Alcohol Use						
Drug Use						
Eating Disorder						
Abuse/Neglect						
Self harm behaviors						
Social Anxiety						
Sleep Problems						
Other						

Does your child have any history of trauma? (i.e., sexual assault, been in an accident, witnessed violence, history of abuse) □yes □no

Social Media and Technology:

What forms of technology does your child use:
□ computer □ iPad/tablet □ cell phone □gaming system(s)_____

Which Social Media sites does your child use:
□ texting □snapchat □instagram □email □≈ □twitter □ TikTok □Youtube □tumblr □other(s)_____

Do you monitor you child's:
□ texting □email □snapchat □instagram □TikTok □Youtube □ tumblr □gaming
□other_____
□ I don't monitor any of their activity
How well do you understand the technology your child is involved in?
□not at all □ a little □moderate amount □very well

Approximately how many total hours does your child use screens (computer, phone, gaming, iPad/tablet): Weekdays_____ Weekends_____

Please list any other areas of concern.

_____
_____
_____