

Tammy Powell, PCC, LLC
CHILD & ADOLESCENT BACKGROUND QUESTIONNAIRE

The following is a questionnaire on your child's development, medical history, and current functioning at home and at school. This information will help 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: _____
Birth date: _____ Age: _____ Grade: _____ Name of School: _____

Address: _____ City: _____ State: _____ Zip: _____
Home phone #: _____ Cell #: _____ Work #: _____

Who referred you/your child?: _____
Person filing out this form: Mother Father Stepmother Stepfather Other: _____

Biological Mother's Name: _____ Age: _____ Highest Grade Completed: _____
Degree/Diploma (if applicable): _____ Occupation: _____
hours a week: _____

Biological Father's Name: _____ Age: _____ Highest Grade Completed: _____
Degree/Diploma (if applicable): _____ Occupation: _____
hours a week: _____

Marital status of biological parents: 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? (Check one) Mother Father Joint/Both Other: _____

Step-father's Name: _____ Age: _____ Occupation: _____
Step-mother's Name: _____ Age: _____ Occupation: _____

If this child is not living with either biological parent: Reason: _____

Adoptive parents Foster parents Other family members Group home Other: _____
Name(s) of legal guardian(s): _____

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 list first language: _____
Age at which your child learned English: _____

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 Sleepwalking Trouble sleeping (describe): _____
 Eats poorly Picky eater Eats excessively

Social Development

- Prefers to be alone Shy or timid More interested in objects than people
 Difficulty making friends Plays or socializes with younger children Teased by other children
 Bullies other children Does not seek friendships with peers Not sought out for friendship by peers

- Does not play or socialize with other children outside of school Difficulty seeing another person's point of view
 Doesn't empathize with others Overly trusting of others
 Overly familiar with people Easily taken advantage of
 Overly attached to certain people Difficulty understanding humor

Behavior

- Stubborn Irritable Frequent tantrums
 Strikes out at others Throws things at others Destroys things
 Angry or resentful Oppositional Negativistic
 Lying Argues with adults Low frustration threshold
 Daredevil behavior Runs away Blames others for own mistakes
 Needs a lot of supervision Talks excessively Impulsive (does things without thinking)
 Skips school Interrupts frequently Poor sense of danger
 Purposely harms or injures self Dangerous to self or others Talks about hurting self
 Not affected by negative consequences Steals Depressed
 Cries frequently Sucks thumb Excessively worried and anxious
 Alcohol abuse Drug abuse Overly attached to certain objects
 Not affected by praise Sexually active Overly preoccupied with details
 Wets self during the day Wets bed Motor/Vocal tics
 Poor bowel control (soils self) Overreacts to noises Overreacts to touch
 Fails to react to loud noise Poor sense of danger Has blank spells
 Excessive daydreaming/fantasy life Bites nails Picks nose
 Masturbation in public places Bangs head Other: _____
 Unusual fears, habits, repetitive behaviors, or mannerisms: _____

Motor Skills

- Poor fine motor coordination Poor gross motor coordination Clumsy
 Cannot tie shoes Cannot dress self Difficulty walking
 Difficulty running Cannot throw or catch

EDUCATION PROGRAM

Name of your child's primary teacher: _____ Phone: _____

Does your child have an individual education plan (IEP) or modified learning program? Yes (date of last update _____) No

If yes, are you satisfied with the IEP? Yes No If not satisfied, please explain: _____

Has your child ever repeated a grade? Yes No If yes, what grade(s) and why? _____

Is your child's curriculum modified? Yes No If yes, please describe: _____

Is your child in any special education classes? Yes No If yes, please describe: _____

Is your child receiving assistance at school? Yes No If yes, please describe: _____

Has your child been suspended or expelled from school? Yes No If yes, please describe: _____

Has your child ever received tutoring outside of school? Yes No If yes, please describe: _____

Rate your child's academic performance relative to other children of the same age. Please estimate the grade level your child is functioning at in the given area if he or she is above or below average.

	Above Average	Average	Below Average	Impaired	Grade Level
Handwriting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Punctuation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vocabulary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reading speed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reading comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Math skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Check any problems reported from school:

- | | | |
|---|---|--|
| <input type="checkbox"/> Difficulty sustaining attention | <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Daydreaming |
| <input type="checkbox"/> Fidgeting / restless | <input type="checkbox"/> Frequently gets out of seat | <input type="checkbox"/> Difficulty working quietly |
| <input type="checkbox"/> Difficulty working independently | <input type="checkbox"/> Doesn't want to be called on | <input type="checkbox"/> Blurts out answers |
| <input type="checkbox"/> Teased by other children | <input type="checkbox"/> Talking back | <input type="checkbox"/> Refusing to do work |
| <input type="checkbox"/> Bullies other children | <input type="checkbox"/> Fighting <input type="checkbox"/> Messy / disorganized | <input type="checkbox"/> Does not like school |
| <input type="checkbox"/> Truant | <input type="checkbox"/> Excessively tired or sleepy | <input type="checkbox"/> Difficulty following instructions |
| <input type="checkbox"/> Doesn't respect the rights of others | <input type="checkbox"/> Shifts from one activity to another | <input type="checkbox"/> Won't wait his/her turn |
| <input type="checkbox"/> Does better in one-to-one relationship | <input type="checkbox"/> Doesn't cooperate well in group activities | |

Describe briefly other classroom or school problems if applicable: _____

COGNITIVE SKILLS

Rate your child's cognitive skills relative to other children of the same age.

	Above Average	Average	Below Average	Impaired
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problem solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory for events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organizational skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory for facts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning from experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conceptual thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall Intelligence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check any specific problems:

- | | |
|--|---|
| <input type="checkbox"/> Poor articulation/pronunciation | <input type="checkbox"/> Difficulty finding words to express self |
| <input type="checkbox"/> Disorganized speech | <input type="checkbox"/> Talks too loudly or softly |
| <input type="checkbox"/> Talks like a younger child | <input type="checkbox"/> Forgets to do things |
| <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Frequently forgets instructions |
| <input type="checkbox"/> Frequently loses belongings | <input type="checkbox"/> Difficulty planning tasks |
| <input type="checkbox"/> Doesn't foresee consequences of actions | <input type="checkbox"/> Slow thinking |

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

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

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? Yes No

If yes, what kind? _____

Smoke? Yes No If yes, how many cigarettes each day? _____

Drink alcoholic beverages? Yes No If yes, what kind? _____

Approximately how much alcohol was consumed each day? _____

Use drugs? 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 (if known): ____ / ____

Were there any indications of fetal distress: Yes No If yes, for what reason? _____

Check any that apply to the birth: Labor induced Forceps Breech Caesarean: for what reason?

What was your child's birth weight? _____

Check any that apply following birth: Jaundice Breathing problems Incubator Birth defect, describe: _____

Were there any other complications? Yes No If yes, describe: _____

Was there any maternal depression during the immediate post-natal period? _____ If yes, please describe: _____

What was your first impression of your baby? _____

Were there any feeding problems? Yes No If yes, describe: _____

Were there any sleeping problems? Yes No If yes, describe: _____

Were there any growth or development problems during the first few years of life? Yes No If yes, describe: _____

Were any of the following present (to a significant degree) during infancy or the first few years of life?

- | | | |
|--|---|--|
| <input type="checkbox"/> Unusually quiet or inactive | <input type="checkbox"/> Did not like to be held or cuddled | <input type="checkbox"/> Not alert |
| <input type="checkbox"/> Difficult to soothe | <input type="checkbox"/> Colic | <input type="checkbox"/> Excessive sleep |
| <input type="checkbox"/> Excessive restlessness | <input type="checkbox"/> Diminished sleep | <input type="checkbox"/> Head banging |
| <input type="checkbox"/> Constantly into everything | <input type="checkbox"/> Excessive number of accidents compared to other children | |

Please indicate the approximate age in months or years at which your child showed the following behaviors. If you feel that you child was early or late in showing a listed behavior, please indicate by checking the appropriate box. Check never if your child has never shown the listed behavior.

	Age	Early	Late	Never
Smiled	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tied shoelaces	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rolled over	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressed self	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sat alone	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fed self	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawled	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder trained, day	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder trained, night	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walked	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ran	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel trained	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Babbled	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rode tricycle	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First word	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rode bicycle	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sentences	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY

Name of pediatrician: _____ Pediatrician phone #: _____
 Approx date of last exam: _____

Place a check next to any illness or condition that your child has had.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Ear infection | <input type="checkbox"/> German measles | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Severe headaches | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Bone or joint disease |
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Jaundice/hepatitis | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High fever | <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Injuries to head | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Broken bones | <input type="checkbox"/> Eczema or hives |
| <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Suicide attempt | <input type="checkbox"/> Operations | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Visual problems | <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Stomach pumped | <input type="checkbox"/> Other: _____ | | |

CURRENT MEDICATIONS

List all medications that your child is currently taking:

<u>Medication</u>	<u>Reason Taken</u>	<u>Dosage (If known)</u>	<u>Start Date</u>

FAMILY MEDICAL HISTORY

Place a check next to any illness or condition that any member of the immediate family (i.e., brothers, sisters, aunts, uncles, cousins, grandparents) has had. Please note the family member’s relationship to the child.

- | | |
|--|--|
| <input type="checkbox"/> Seizures or Epilepsy _____ | <input type="checkbox"/> Neurological illness or disease _____ |
| <input type="checkbox"/> Attention deficit _____ | <input type="checkbox"/> Mental illness _____ |
| <input type="checkbox"/> Hyperactivity _____ | <input type="checkbox"/> Depression or anxiety _____ |
| <input type="checkbox"/> Learning disabilities _____ | <input type="checkbox"/> Tics or Tourette’s syndrome _____ |
| <input type="checkbox"/> Mental retardation _____ | <input type="checkbox"/> Alcohol or drug abuse _____ |
| <input type="checkbox"/> Childhood behavior problems _____ | <input type="checkbox"/> Suicide attempt _____ |

List had any previous assessments that your child has had:

	<u>Dates of Testing</u>	<u>Name of Examiner</u>
Psychiatric: Y / N		
Psychological: Y / N		
Neuropsychological: Y / N		
Educational: Y / N		
Speech Pathology: Y / N		
Other:		

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

<u>Type of Treatment</u>	<u>Dates</u>	<u>Name of Therapist</u>

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: _____

List any special interests that your child has: _____

List any sports your child plays: _____

What are your child’s assets or strengths? _____

Has your child ever been in trouble with the law? Yes No If yes, please describe: _____

