

CHILD HISTORY QUESTIONNAIRE

This questionnaire is part of your child's overall evaluation. Please complete it before your interviews. Doing so has several advantages. You will know ahead of time many of the factual questions to be asked by the evaluator. You can answer the questions in the place and at the speed at which you feel most comfortable. You will have the opportunity to look up information that you may not remember.

This questionnaire is an opportunity for you to provide basic information about each of the major areas of your child's life. It is not a test. It is a written interview. Just like an interview, what you write here may be used in the examiner's report or opinion. There are no "right" answers and no "trick" questions. You may not remember some of the information requested and then just answer the best you can. Of necessity, some of the information is personal. Keep in mind that you may decline to answer any items that you wish.

If there is not enough space for you to give a full answer, present the most important information in the space provided. You will have a chance to discuss the questions further with the examiner during your interview. The examiner's job is to perform an independent, thorough, and objective evaluation. Your cooperation is very much appreciated.

It is preferable that both parents accompany the child to the consultation on _____ .

I. CHILD'S IDENTIFICATION

Name: _____ Today's date: ____ / ____ / ____
Date of birth: ____ / ____ / ____ Age: ____ School grade: ____ Sex: ____ Phone: ____ / ____ / ____
Address: _____
Street City State ZIP

II. REFERRAL INFORMATION

Source of Referral

Name: _____ Phone: ____ / ____ / ____
Address: _____
Street City State ZIP

Purpose of consultation - *Write a brief summary of the main problem:*

III. CHILD'S FAMILY

Caregivers

Place checks in the appropriate boxes.

Relationship to Child	A	B	This caregiver is deceased.	If deceased, caregiver's age at time of death
	The child currently lives with:	Non-residential adults involved with child		
Natural mother				
Natural father				
Stepmother				
Stepfather				
Adoptive mother				
Adoptive father				
Foster mother				
Foster father				
Other (specify) _____				
Other (specify) _____				

A. For each caregiver checked in column **A**, fill in the following information:

(List additional caregivers in column **A** on the reverse side.)

1. Relationship to child: _____

Name: _____ Age: _____

Employer name: _____ Occupation: _____

Employer city/state: _____ Work phone: _____ / _____ / _____

Medical or mental health issues: _____

2. Relationship to child: _____

Name: _____ Age: _____

Employer name: _____ Occupation: _____

Employer city/state: _____ Work phone: _____ / _____ / _____

Medical or mental health issues: _____

B. For the caregiver checked in column **B** who is **MOST** involved with the child, fill in the following information:

Relationship to child: _____

Name: _____ Age: _____

Employer name: _____ Occupation: _____

Employer city/state: _____ Work phone: _____ / _____ / _____

Medical or mental health issues: _____

III. CHILD'S FAMILY (continued)

Child's Siblings

In order by chronological age, list all brothers, sisters, half brothers, half sisters, step brothers, step sisters, and adopted brothers and sisters. If a sibling is deceased, give his/her age at time of death.

Name: _____ Deceased? Yes No Age: _____
Occupation/School grade: _____
Address city/state: _____
Medical, mental health, social or academic issues: _____

Name: _____ Deceased? Yes No Age: _____
Occupation/School grade: _____
Address city/state: _____
Medical, mental health, social or academic issues: _____

Name: _____ Deceased? Yes No Age: _____
Occupation/School grade: _____
Address city/state: _____
Medical, mental health, social or academic issues: _____

Name: _____ Deceased? Yes No Age: _____
Occupation/School grade: _____
Address city/state: _____
Medical, mental health, social or academic issues: _____

Name: _____ Deceased? Yes No Age: _____
Occupation/School grade: _____
Address city/state: _____
Medical, mental health, social or academic issues: _____

List additional siblings and their information on reverse side.

Other Relatives

Have any blood relatives (not including this child or his/her siblings) ever had problems similar to those your child has? If so, describe. _____

IV. HEALTH HISTORY (continued)

Delivery

Type of labor: spontaneous induced
Forceps, if used: high mid low
Type of delivery: normal breach Caesarean
Baby's size was: normal for age small for age
Birth weight: pounds ounces
Duration of labor : hours

Complications:

Yes No

- Cord around neck
 Cord presented first
 Hemorrhage
 Infant injured during delivery
 Other complications (If yes, specify.)

Immediately After Delivery

Length of baby's hospital stay: days
Apgar score:
Suck: strong weak

Complications:

Yes No

- Respiration delayed (If yes, how long?) minutes
 Cry was delayed (If yes, how long?) minutes
 Incubator care (If yes, how long?) days
 Mucus accumulation
 Jaundice
 Rh factor incompatibility
 If yes, with transfusion required
 Cyanosis (baby was blue)
 Diarrhea
 Vomiting
 Birth defect (If yes, specify.)
 Infection (If yes, specify.)
 Other (If yes, specify.)

Infancy, Childhood and Adolescence

Yes No

- Head injury
 If yes, with unconsciousness
 Convulsions
 If yes, with fever
 Coma
 Meningitis or encephalitis

IV. HEALTH HISTORY (continued)

Indicate any treatment your child has had, individually or with others, with a school counselor, pastor, physician, psychologist, psychiatrist, or other mental health professional.

Dates		Number of Sessions	Type of Counseling	Medications Prescribed	Dates Prescribed	
Start	End				Start	End

Alcohol Use History

Age	What Type	Where	How Often	How Much
Birth to 13				
14 to 17				
18 to 21				

Drug Use History

Age	What Type	Where	How Often	How Much
Birth to 13				
14 to 17				
18 to 21				

Present Medical Status

Height	<input type="text"/>	Weight	<input type="text"/>
Illnesses	<input type="text"/>		
Ongoing medications	<input type="text"/>		

V. DEVELOPMENTAL HISTORY (continued)

Childhood-Adolescence Period

Coordination

Check the appropriate box.

Skill	Good	Average	Poor
Walking			
Running			
Throwing			
Catching			
Tying shoelaces			
Buttoning			
Writing			
Athletic abilities			

Needs Heading

Instructions

Yes No

- Does your child understand directions and situations as well as other children of his or her age?
- Does your child seek friends with peers?
- Is your child sought by peers for friendship?
- Does your child frequently prefer to stay alone?
- Is your child frequently sad, cry often?
- Does your child have an eating problem either with eating too much or too little?
- Does your child have a sleeping problem either sleeping too much or too little?
- Is your child frequently irritable?
- Has your child ever talked of suicide or wished to be dead?
- Has your child showed alack of interest in activities he or she formerly enjoyed?
- Does your child talk about hearing or seeing unusual things or people?
- Does your child feel worthless or guilty?
- Is your child aware of other peoples' feelings?
- Does your child react negatively to change?
- Does your child require supervision to do most tasks?

V. DEVELOPMENTAL HISTORY (continued)

Heading(continued)

*Yes No Does your child **complete** the following activities without your help?*

- Dress himself or herself
- Perform personal grooming and health care habits
- Get to school or appointments on time
- Get up in the morning without reminders
- Fix simple meals for himself or herself
- Perform simple household duties independently
- Manage money
- Answer phone and take messages
- Wash own clothes
- Take medications independently
- Greet guests appropriately

Yes No Does your child exhibit any of the following behaviors to an excessive or exaggerated degree?

- Hyperactivity (high activity level)
- Poor attention span
- Impulsivity (poor self control)
- Low frustration threshold
- Temper outbursts
- Sloppy table manners
- Interrupts frequently
- Doesn't listen when spoken to
- Sudden outbursts of physical abuse of other children
- Acts like he or she is driven by a motor
- Wears out shoes more frequently than siblings
- Heedless of danger
- Excessive number of accidents
- Doesn't learn from experience
- Poor memory
- More active than siblings

Does your child play primarily with children who are: his/her own age younger older

Describe, briefly, any problems your child may have with peers.

V. DEVELOPMENTAL HISTORY (continued)

Interests and Accomplishments

What are your child's main hobbies and interests?

What are your child's areas of greatest accomplishment?

What does your child enjoy doing most?

What does your child dislike doing most?

Describe your child's current involvement in sports, recreational, or other team, group, or individual athletic activities. Also describe his or her involvement in leisure activities or membership in groups.

VI. EDUCATIONAL HISTORY

In chronological order, list where your child attended or is attending nursery, primary, middle, junior high and high school. Indicate under "Comments" if this was regular or special education and if your child was suspended or expelled.

Dates	Grades	Name of School	City and State of School	Comments

VI. EDUCATIONAL HISTORY (continued)

Academic

Rate you child's school experiences related to *academic learning*.

Level	Good	Average	Poor
Nursery school			
Kindergarten			
Current grade			

To the best of your knowledge, at what grade level is your child functioning?

Subject	Grade Level
Reading	
Spelling	
Arithmetic	

How would you rate your child's intelligence?

Below average Average Above average

Yes No

- Has your child had an I.Q. test? (If yes, specify which one and score.)
- Has your child ever repeated a grade?
- Is your child currently in placed in a special class?
- Is your child receiving special therapy or remedial work?

Describe, briefly, any academic problems your child has.

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Classroom Behavior

Rate you child's school experiences related to *behavior*.

Level	Good	Average	Poor
Nursery school			
Kindergarten			
Current grade			

