HISTORY AND BACKGROUND QUESTIONNAIRE
George Mason University Cognitive Assessment Program
10/27/07 Version

Please answer all of the questions below, even if some may not apply directly to your child. In order to help us more fully learn about your child, you should also bring your provider photocopies of your child’s recent school report cards, standardized test score results, and any educational, medical, or psychological reports. Please PRINT so we can read your handwriting.

IDENTIFYING INFORMATION

CHILD’S NAME: _________________________________________________________________  DATE TODAY: /___/___/___/

GENDER (circle): Male Female  CHILD’S AGE: __________years  GRADE: _____________  BIRTH DATE: /___/___/___/  

RACE/ETHNICITY (circle any that apply):

American Indian/Alaskan Native  Asian  Black/African American  Hispanic/Latino  Hawaiian/Pacific Islander  White  Other

LEGAL GUARDIAN(S): _______________________________________________________

RELATION TO CHILD: ____________________

HOME ADDRESS: ___________________________________________________________

DAYTIME PHONE___________________  CELL/OTHER PHONE_________________

CHILD’S SCHOOL: ___________________________________________________________

COUNTY: ____________________

RECENT ABILITY or ACHIEVEMENT TESTS TAKEN: _______________________________

Person filling out this form (circle):  Mother  Father  Stepmother  Stepfather  Other ________________________________

REASON FOR REFERRAL

Describe the reason(s) you have brought your child to be tested. ________________________________________________________________

Describe early indications of above average ability and the age of your child at the time. ________________________________________________________________

In what types of situations does your child most show his or her potential? ________________________________________________________________

Do you have any concerns about his or her current school or education? ________________________________________________________________

Has the child received a previous evaluation or intervention for similar reasons?  Yes  No

If Yes, when and with whom? ________________________________________________________________

Is the child on any medication at this time?  Yes  No  If yes, please write name(s): ________________________________

Who referred you here? ________________________________  Title: ________________________________
**DEVELOPMENTAL HISTORY**

**PREGNANCY:**

- Was your child adopted?  Yes  No
- Was the pregnancy planned?  Yes  No
- Duration of Pregnancy (weeks or months):  ______________________

**Complications of this pregnancy included:**

- excessive vomiting
- excessive staining or blood loss
- high blood pressure
- threatened miscarriage
- infection(s)
- toxemia
- diabetes
- maternal anemia
- nutrition/weight problems
- ultrasound
- amniocentesis or CVS
- loss of consciousness

**During the pregnancy, did the mother:**

- suffer from illness or disease
- undergo surgery
- take medication
- undergo X-ray studies
- smoke tobacco
- consume alcohol
- use drugs

**Mother’s age at child’s birth:**  ________________________  Father’s age at child’s birth:  ________________________

**DELIVERY AND POST-DELIVERY:**

- Duration of Labor:  _______________ hours  Birth Weight:  _______________ lbs. _______________ ozs.  Length:  _______________________
- Type of Labor (circle):  Spontaneous  Induced
- Forceps (circle):  Not used  High  Mid  Low
- Type of Delivery (circle):  Normal  Breech  Caesarean
- Anesthesia at delivery:  _______________________

**Delivery Complications:**

- None
- Cord around neck
- Cord presented first
- Hemorrhage
- Delay or distress in respiration
- Meconium aspiration
- Delay in cry
- Multiple births
- Injury to infant
- Other  ________________

**Total days baby was in hospital after delivery:**  ________________________  Total days baby was in incubator:  ________________________

**Medications administered to baby:**  ________________________  APGAR Ratings (if known):  _____ at 5 minutes after birth

**Neonatal Complications:**

- None
- Breathing problems
- Infection
- Cyanosis (turned blue)
- Jaundice (yellow)
- Diarrhea
- Feeding problems
- Other  ________________

**DEVELOPMENTAL MILESTONES:**

The following is a list of infant/preschool/school-age behaviors. For each behavior you can remember, please indicate the age in months (m) or years (y) at which your child first demonstrated it. If you are not certain of the age but have some idea, write the age followed by a question mark.

<table>
<thead>
<tr>
<th>Age</th>
<th>Behaviors</th>
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<th>Behaviors</th>
<th>Age</th>
<th>Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rolled from stomach to back</td>
<td></td>
<td>Spoke first word</td>
<td></td>
<td>Smiles spontaneously</td>
</tr>
<tr>
<td></td>
<td>Sat without support</td>
<td></td>
<td>Put several words together</td>
<td></td>
<td>Reaches for familiar people</td>
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<tr>
<td></td>
<td>Crawls forward</td>
<td></td>
<td>Can show major body parts</td>
<td></td>
<td>Upset when separated from mother</td>
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<tr>
<td></td>
<td>Walked holding someone’s hand</td>
<td></td>
<td>Can give first and last names</td>
<td></td>
<td>Aware of differences between sexes</td>
</tr>
<tr>
<td></td>
<td>Walked without support</td>
<td></td>
<td>Can recognize letters</td>
<td></td>
<td>Separates easily from mother</td>
</tr>
<tr>
<td></td>
<td>Handles spoon well</td>
<td></td>
<td>Sounded out new words</td>
<td></td>
<td>Plays with several children</td>
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<tr>
<td></td>
<td>Rides tricycle</td>
<td></td>
<td>Wrote first word</td>
<td></td>
<td>Dressed and undressed self</td>
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<tr>
<td></td>
<td>Uses scissors to cut out pictures</td>
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<tr>
<td></td>
<td>Rides bicycle without training wheels</td>
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**Compared with other children, your child's early development was (circle):**

- Normal  Delayed  Advanced

Describe any early indications of delayed or advanced ability.  ________________________
EDUCATIONAL BACKGROUND:

Did your child attend preschool and/or kindergarten?  Yes  No  At what ages? ___________________________________________

Did teachers report anything special or unusual about his or her early school performance? ________________________________________
_________________________________________________________________________________________________________________

Did your child show unusual abilities in any academic area (e.g., reading, math) at an early age?  Yes  No  If Yes, explain ___________
_________________________________________________________________________________________________________________

Has your child attended any school with a nontraditional approach to teaching and learning?  Yes  No  If Yes, explain ___________

Has your child changed schools for reasons other than normal academic progression?  Yes  No  If Yes, when and for what reason?
_________________________________________________________________________________________________________________

Has your child skipped or repeated a grade in school?  Yes  No  If Yes, explain ____________________________________________

RECENT SCHOOL PERFORMANCE:

Please write the grades (and subjects) on your child’s most recent report card, from highest to lowest. _______________________________
_________________________________________________________________________________________________________________

What activities or subjects at school does your child most enjoy? ____________________________________________________________
_________________________________________________________________________________________________________________

What activities or subjects at school does your child least enjoy? _____________________________________________________________
_________________________________________________________________________________________________________________

Has your child’s school performance in (or attitude toward) school changed in the last two years?  Yes  No  If Yes, explain ___________
_________________________________________________________________________________________________________________

Does your child have any special needs or accommodations at school?  Yes  No  If Yes, explain _______________________________

Does your child receive any special services at school?  Yes  No  If Yes, explain ___________________________________________
_________________________________________________________________________________________________________________

Do you have any concerns about the quality of your child’s school or teachers?  _______________________________
_________________________________________________________________________________________________________________

Describe any concerns about social or emotional problems, or other matters, that may affect your child’s school functioning. ___________
_________________________________________________________________________________________________________________

Does your child have excessive absences from school?  Yes  No  If Yes, explain _____________________________________________
## HOME AND SOCIAL INFORMATION

**Mother:** ___________________________  **Age:**___  **Education:**______  **Occupation:** ___________________________

**Father:** ___________________________  **Age:**___  **Education:**______  **Occupation:** ___________________________

**Stepparent:** ___________________________  **Age:**___  **Education:**______  **Occupation:** ___________________________

What is the household’s gross annual income? (please circle one)

- $100,000 and above
- $80,000 to $99,000
- $60,000 to $79,000
- $40,000 to $59,000
- $20,000 to $39,999
- $10,000 to $19,999
- Below $10,000

What adults are living in the home with the child? _______________________________________________________________________

If parents are separated or divorced, who has legal custody of the child? _______
**How old was child when the separation occurred?______**

If you are divorced or separated, how often does the other parent see your child?

- Weekly or more often
- Once or twice a month
- Several times a year
- Rarely

List all people living in household:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Child</th>
<th>Age</th>
<th>School/Learning</th>
<th>Behavior</th>
<th>Nervous or Mental</th>
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</table>

Any history of problems in these areas? - - - - - - - - - - - - -

About how many close friends does your child have?  
- None
- One
- Two or three
- Four or more

About how many times a week does your child do things with friends outside of regular school hours? _______________________________

Does your child participate in any extracurricular activities or social organizations?  
- Yes
- No
- If Yes, please list ___________________

Beyond family, what is the age group of the people that your child prefers to be around?  
- Younger
- Same-Age
- Older
- Adults

How well does your child relate to other children at school? _______________________________

How does your child adapt socially to …  
- One-on-one situations? _______________________________
- Small group situations? _______________________________
- Large group situations? _______________________________

Describe any major stresses that might be affecting your child now (e.g., death, divorce, trauma): _______________________________
Does your child speak a language other than English at home? Yes No If Yes, what is this language? __________________________

Which language is dominant for your child? (most preferred or most comfortable language?) _______________________________

What was the first language that your child was exposed to in the home (at birth)? _________________________________

At what age was a second language introduced to your child? _________________________________

If English is a second language, at what age did your child begin learning English? _________________________________

How well does your child speak English? (Check one) ___Very well ___Well ___Not well ___Not at all

At school what was the FIRST language of instruction? _________________________________

If English is a second language, has your child received FORMAL English language instruction? _________________________________

At what age did Formal English language instruction begin? _________________________________

What are your child's favorite activities? 1._________________________ 2.________________________ 3._______________________

Is any legal action currently underway in this family? Yes No If Yes, explain ___________________________________________

CHILD’S MEDICAL HISTORY

Has your child been diagnosed with any behavioral, educational, medical, neurological, or psychiatric disorder, such as Attention Deficit Hyperactivity Disorder (ADHD), Learning Disorder (LD), or Anxiety and Mood Disorders? Yes No If Yes, please specify:

_________________________________________________________________________________________________________________

__________________________________________________________

VISION: Date of most recent vision exam __________________

Does your child have any vision problems? Yes No If Yes, is his or her vision corrected with (circle one):  Eyeglasses Contact lenses

HEARING: Date of most recent hearing exam ________________

Does your child have any hearing problems? Yes No If Yes, has his or her hearing been treated? _________________________________

Has your child ever had ear infections? Yes No If Yes, what was his or her age at the time of the first infection? _________________________________

Total number of infections: ___________ Average duration of infections? ___________ Number of infections before age 3: __________

Names of antibiotics used: _____________________________________ Was an examination conducted by an audiologist? Yes No

Were tubes inserted in the child’s ears? Yes No If Yes, at what age(s) and for how long? ______________________________________

Check any of the following problems that were present: ___Comprehension problems ___Covered ears with hands when noisy ___Irritability ___Language delay ___Loud television or radio ___Pain complaints ___Speech problems ___Talks loudly

MOTOR COORDINATION:

Which hand does your child prefer for writing or drawing? ___Right hand ___Left hand ___Either ___Don’t know

Place a check next to any motor behavior on which your child seems awkward or uncoordinated: ___Writing ___Using eraser ___Using scissors ___Using eating utensils ___Throwing ___Catching ___Walking ___Running

SENSORY STIMULATION:

Place a check next to any areas of unusual sensitivity displayed by your child: ___Bright light ___Loud sound ___Being touched
Is your child allergic to any medicines, foods, or other substances?  Yes  No  If Yes, please specify ________________________________

**CHILDHOOD ILLNESSES:**
Place a check next to any illness or condition that your child has had. Write the approximate date (or child's age at the time) next to illnesses within the last two years.

<table>
<thead>
<tr>
<th>Illness or Condition</th>
<th>Illness or Condition</th>
<th>Illness or Condition</th>
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<tbody>
<tr>
<td>Anemia</td>
<td>Epilepsy or seizures</td>
<td>Loss of consciousness</td>
</tr>
<tr>
<td>Arthritis (juvenile)</td>
<td>Fainting</td>
<td>Malnutrition</td>
</tr>
<tr>
<td>Bleeding problems</td>
<td>Fatigue (if chronic and severe)</td>
<td>Measles</td>
</tr>
<tr>
<td>Bone or joint disease</td>
<td>Hay fever</td>
<td>German measles</td>
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<tr>
<td>Broken bones</td>
<td>Head injury</td>
<td>Meningitis</td>
</tr>
<tr>
<td>Cancer</td>
<td>Headaches (frequent or severe)</td>
<td>Mumps</td>
</tr>
<tr>
<td>Chicken pox</td>
<td>Heart disease</td>
<td>Paralysis</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Hepatitis</td>
<td>Rheumatic fever</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>High blood pressure (hypertension)</td>
<td>Scarlet fever</td>
</tr>
<tr>
<td>Eczema or hives</td>
<td>High fever (greater than 104 degrees)</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Encephalitis</td>
<td>Jaundice</td>
<td>Whooping cough</td>
</tr>
</tbody>
</table>

**MEDICAL TREATMENT:**
Date of most recent medical exam ________________

Pediatrician's name: ______________________________________________________________________________________________

If your child has ever undergone an operation or hospitalization, please list the problem below (usually an illness), the child’s age, and the medical procedures that were implemented during the hospitalization.

<table>
<thead>
<tr>
<th>Problem (or illness)</th>
<th>Age</th>
<th>Medical Procedures during the Hospitalization</th>
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</thead>
<tbody>
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</table>

If your child has ever been treated with prescription medication other than for colds and minor infections, please list them below:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Age</th>
<th>Reason Prescribed</th>
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</table>
### Family Medical History

Have any other family members shown advanced abilities or talents?  
Yes  
No  
If Yes, who and what abilities?  
__________________________

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Relationship to child</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD or Hyperactivity</td>
<td></td>
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<tr>
<td>Anxiety or Worry Problem</td>
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<tr>
<td>Depression</td>
<td></td>
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<tr>
<td>Learning problems</td>
<td></td>
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<tr>
<td>Manic-Depressive Disorder</td>
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<tr>
<td>Reading Problem</td>
<td></td>
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<tr>
<td>Speech or Language Problem</td>
<td></td>
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<tr>
<td>Sexual/physical abuse</td>
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<tr>
<td>High Blood Pressure</td>
<td></td>
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<tr>
<td>Huntington’s Chorea</td>
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<tr>
<td>Kidney Disease</td>
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<tr>
<td>Mental Retardation</td>
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<tr>
<td>Migraine Headaches</td>
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<tr>
<td>Muscular Dystrophy</td>
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<tr>
<td>Multiple Sclerosis</td>
<td></td>
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<tr>
<td>Parkinson’s Disease</td>
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<tr>
<td>Physical Handicap or Disability</td>
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<tr>
<td>Seizures or Epilepsy</td>
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<tr>
<td>Sickle Cell Anemia</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Suicide attempt</td>
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<tr>
<td>Tay-Sachs Disease</td>
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<tr>
<td>Tourette’s Syndrome or Tic Disorder</td>
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<tr>
<td>Tuberculosis</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

Is there any other information that you think may help us in understanding and working with your child?  
__________________________