CHILD HISTORY & BACKGROUND QUESTIONNAIRE

George Mason University Center for Psychological Services
1/12/11 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.

BASIC INFORMATION

CHILD'S NAME: ____ DATE TODAY: /_____/_____/_____/

GENDER (circle): Male Female CHILD'S AGE: __________years GRADE: _____________ BIRTH DATE: /_____/_____/_____/
Month / Day /Year

RACE (circle any that apply):
American Indian/Alaskan Native Asian Black/African American Hawaiian/Pacific Islander White Other

Ethnicity (circle any that apply): Hispanic or Latino Not Hispanic or Latino

LEGAL GUARDIAN(S): ____ RELATION TO CHILD: ______________

HOME ADDRESS: ____ DAYTIME PHONE___________________

____ CELL/OTHER PHONE_________________

CHILD'S SCHOOL: ____ COUNTY: ________________

EDUCATIONAL PLACEMENT/CLASSIFICATION: __________________________ MOST RECENT GRADES: ___________________

RECENT ABILITY or ACHIEVEMENT TESTS TAKEN: ____

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

REASON FOR REFERRAL

Who referred you here? ______________________________ Phone Number:______________________________

Briefly describe the reason(s) you have brought your child to GMU. ____

____

____

How long has this reason been noticeable to you? ________________ How old was your child when it was first noticed? ______________

What seems to help it? ____

What seems to make it worse? ____

Have any other family members shown similar characteristics? Yes No Whom? ______________________________

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):______________________________

DEVELOPMENTAL HISTORY

PREGNANCY:

Was your child adopted? Yes No If yes, child age at adoption: ___________ (if yes, fill out maternal history as best as possible)

Mother's age at child's birth: ________________________________ Father's age at child's birth: ________________________________

Duration of Pregnancy (weeks or months): ____

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

Complications of this pregnancy included:

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

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
___ 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
___ Addiction
___ Anemia
___ Birth defects
___ Breathing problems
___ Cyanosis (turned blue)
___ Diarrhea
___ Feeding problems
___ Infection
___ Jaundice (yellow)
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.

Age Behaviors
_____Rolled from stomach to back
_____Sat without support
_____Crawls forward
_____Walked holding someone's hand
_____Walked without support
_____Handles spoon well
_____Rides tricycle
_____Uses scissors to cut out pictures
_____Rides bicycle without training wheels

Age Behaviors
_____Babbled
_____Spoke first word
_____Put several words together
_____Can show major body parts
_____Can give first and last names
_____Can recognize letters
_____Sight read first word
_____Sounded out new words
_____Wrote first word

Age Behaviors
_____Smiles spontaneously
_____Reaches for familiar people
_____Upset when separated from mother
_____Aware of differences between sexes
_____Separates easily from mother
_____Understands taking turns
_____Goes to the toilet alone
_____Plays with several children
_____Dressed and undressed self

Compared with other children, your child's early development was (circle): Normal Delayed Advanced

Describe any early indications of your child's problems. ____

____

EDUCATIONAL HISTORY

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 BRING IN A COPY OF YOUR CHILD'S MOST RECENT REPORT CARDS.

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 __________________________

Current Educational Problems include:

___difficulty with reading
___difficulty with arithmetic
___difficulty with spelling
___difficulty with writing
___difficulty remembering
___difficulty with being organized
___does not respect rights of others
___fights with classmates
___truancy or avoidance of school
___does not like school
___does not complete homework
___does not sit still in seat
___frequently inattentive or distracted
___disrupts classroom
___does better 1 to 1 than in groups
___does not work well independently

When did school problems begin (or first come to your notice): ____

Describe any other classroom behavioral problem(s): ____

____

Do you have any concerns about the quality of your child's school or teachers? ____

HOME AND SOCIAL INFORMATION

Mother: _____________________________ Age:____ Education:________ Occupation: ______________________________

Father: _____________________________ Age:____ Education:________ Occupation: ______________________________

Stepparent: __________________________ Age:____ Education:________ Occupation: ______________________________

If parents are separated or divorced, who has 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: - - - - - - - - - - - - - Any history of problems in these areas? - - - - - - - - - - - -

Name	Relationship to Child	Age	School/Learning	Behavior	Nervous or Mental

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): ____________________________________

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check next to each technique that you usually use. There also is space for writing in any other disciplinary techniques that you use.

Disciplinary Technique	Disciplinary 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
_____ Threaten child	______ Take away food
_____ Reason with child	______ Punish child another way (describe__________________)
_____ Redirect child's interest	______ Don't use any technique

_____ Other technique (describe____)

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

CHILD'S MENTAL HEALTH 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:

____

Is your child currently in treatment with any mental health or behavioral health provider?

If yes, Name ______________________________ Phone______________________________

For what condition(s)? ____

Note: We will likely need your permission to communicate with this professional.

Briefly describe the nature of service(s) (e.g. individual psychotherapy once per week for anxiety; medication management for mood disorder, etc.):

Age	Diagnosis	Type of Service	Duration of Service

CHILD'S MEDICAL HISTORY

Pediatrician's name: ______________________________ Phone number: ______________________________

Date of most recent exam: ______________________

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.

Problem (or illness) Age Medical Procedures during the Hospitalization

______________________ ____ ____

______________________ ____ ____

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

Medication Age Reason Prescribed

______________________ ____ ____

______________________ ____ ____

VISION

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

Date of most recent vision exam __________________

HEARING

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

Date of most recent hearing exam __________________

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.

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

FAMILY MEDICAL HISTORY

Have any other family members shown similar problems or challenges? Yes No If *Yes*, who? ________________________________

____

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.

	Condition	Relationship to child		Condition	Relationship to child
____	ADHD or Hyperactivity	______________	____	High Blood Pressure	______________
____	Anxiety or Worry Problem	______________	____	Huntington's Chorea	______________
____	Depression	______________	____	Kidney Disease	______________
____	Learning problems	______________	____	Mental Retardation	______________
____	Manic-Depressive Disorder	______________	____	Migraine Headaches	______________
____	Reading Problem	______________	____	Muscular Dystrophy	______________
____	Speech or Language Problem	______________	____	Multiple Sclerosis	______________
____	Sexual/physical abuse	______________	____	Nervous Breakdown or Problems	______________
			____	Parkinson's Disease	______________
____	Alcoholism	______________	____	Physical Handicap or Disability	______________
____	Alzheimer's Disease	______________	____	Seizures or Epilepsy	______________
____	Birth Defect	______________	____	Sickle Cell Anemia	______________
____	Cancer	______________	____	Stroke	______________
____	Cerebral Palsy	______________	____	Suicide attempt	______________
____	Cystic Fibrosis	______________	____	Tay-Sachs Disease	______________
____	Diabetes	______________	____	Tourette's Syndrome or Tic Disorder	______________
____	Drug Addiction or Dependency	______________	____	Tuberculosis	______________
____	Heart Disease or Heart Attack	______________	____	Other________________________	______________
____	Hemophilia	______________			

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

____

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