CHILD/ADOLESCENT QUESTIONNAIRE

This questionnaire asks you to respond to a series of questions about your child and your family. This type of information is very helpful in understanding your child. Please complete as best you can. It is also helpful for you to bring copies of your child's recent report cards, standardized test results, and any previous educational, medical, or psychological reports.

IDENTIFYING INFORMATION

Child's Name: ___________________________________; Date of Birth:____________

Name of Person completing this form and relation to the above child:_____________

____

Gender (circle): Male Female; Child's Age ____________

School Name: __________________________________ Grade:___________________

Mother's Name:_____________________________ Occupation:___________________

Father's Name:______________________________ Occupation:___________________

Biological parents' marital status (circle):

Never Married Partnered Married Separated Divorced Widowed

Phone Number (home):_______________________ (cell):__________________________

(office): __________________________

Child's Pediatrician:______________________________ Phone:_____ _____________

Referral Source:____

REASON FOR REFERRAL

Describe the reason(s) for seeking services:

____

____

____

____

____

____

____

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

If Yes, when and with whom?____

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CHILD'S BIRTH AND DEVELOPMENTAL HISTORY

Pregnancy: Was your child adopted? Yes No

Was the pregnancy planned? Yes No

Pregnancy length in months (or weeks):______________

During the pregnancy with this child the following was present: (check all that apply)

___ suffer from illness/disease ___ excessive vomiting ___ maternal anemia

___ undergo surgery ___ excessive blood loss ___ high blood pressure

___ take medication ___ threatened miscarriage ___ nutrition/weight problems

___ smoke tobacco ___ infection(s) ___ amniocentesis or CVS

___ consume alcohol ___ toxemia ___ ultrasound

___ use drugs ___ diabetes ___ loss of consciousness

Please explain any of the above checked difficulties in detail here:________________

____

____

Delivery and Post-delivery: Duration of labor: __________hours

Type of Labor (circle): Spontaneous Induced

Type of Delivery (circle): Normal Breech Caesarean

Delivery Complications: ___ None ___ Delay or distress in respiration ___ Multiple births

___ Cord around neck ___ Meconium aspiration ___ Injury to infant

___ Cord presented first ___ Delay in cry ___ Hemorrhage

Other: ____

Birth Weight: ___ lbs _____ oz. Length:__________

Child's condition at birth (circle): Poor Good Excellent

Total days baby was in hospital after delivery:_____________________

Neonatal Complications: ___ None ___ Breathing problems ___ Infection

___ Addiction ___ Cyanosis (blue) ___ Jaundice (yellow)

___ Anemia ___ Feeding problems ___ Birth Defects

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.

Behavior	**Approximate Age (if unsure of the age, indicate if developed Early, On time, or Late)**
Rolled from stomach to back	
Sat without support	
Crawled	
Walked without assistance	
Babbled	
Spoke first word	

Behavior	Approximate Age (if unsure of the age, indicate if developed Early, On time, or Late)
Gave first and last name	
Put several words together	
Talked in sentences	
Can recognize letters	
Began to read	
Named Colors	
Wrote first word	
Handled spoon well	
Buttoned Clothing	
Used scissors to cut out pictures	
Rode tricycle	
Rode bicycle	
Dressed and undressed self	
Bladder trained, day	
Bladder trained, night	
Slept independently in own bed	
Upset when separated from caregiver	
Aware of differences between sexes	
Understood taking turns	
Played with several children	

Coordination

	Good	Average	Poor
Walking			
Running			
Throwing			
Catching			
Shoelace Tying			
Coloring/Drawing			
Buttoning			
Handwriting			
Athletic Abilities			

Overall, compared with other children, your child's early development was (circle):
Normal   Delayed   Advanced
Describe any early indications of delayed or advanced ability:______________________________

____

HOME INFORMATION/FAMILY HISTORY

Mother's Name: ______________________________ Age:____________________________

Age at the time of child's birth:____

Education:___________________________________ Occupation:_____________________

Medical Problems:____

Learning/Behavior Problems:____

Drug/Alcohol History:____

History of Depression/Anxiety/Bipolar:____

Pertinent Family History on maternal side (emotional, behavioral, learning, or drug problems):

____

____

Father's Name: ____________________________ Age:__________________________

Age at the time of child's birth:_______________________________________

Education:_________________________________ Occupation:____________________

Medical Problems:____

Learning/Behavior Problems:____

Drug/Alcohol History:____

History of Depression/Anxiety/Bipolar:_______________________________________

Pertinent Family History on paternal side (emotional, behavioral, learning, or drug problems):

____

____

____

What adults live in the home with the child?_____________________________________

If parents are separated/divorced, who has custody of the child?______________________

Age of child at separation?____

If parents are separated/divorced, how often does other parent see the child?____________

____

Siblings and/or others living in the home:

(Name, Age, Relationship, and state any history of Behavior, Learning, Psychiatric problems):

1.____

____

2.____

____

3.____

____

4.____

____

Describe any stressors that might be affecting your child now (i.e. death, divorce, trauma):______

____

____

Does your child speak a language other than English in the home? Yes No

If *Yes*, describe:____

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

EDUCATIONAL HISTORY

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

Did teachers report anything unusual about his or her early school performance? (describe)____

____

Did your child show significant strengths or weaknesses in any academic area at an early age? 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 any grades in school? Yes No

If *Yes*, explain:____

____

Other relevant information related to school performance:______________________________

____

Recent School Performance

Please write the grades (and subjects) on your child's most recent report card or provide a copy of his/her report card:____

____

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:____

Do you have any concerns about the quality of your child's school or teachers? Yes No

If *Yes,* explain:____

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:____

SOCIAL SKILLS

About how many close friends does your child have? (circle) 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?____

Compared to others of the same age, how does your child get along with other children? (circle)

Below Avg Average Above Avg

Compared to others of the same age, how does your child interact with adults? (circle)

Below Avg Average Above Avg

Who does your child prefer to play with (circle)? Family Alone Younger Same age Older Children

Does your child participate in any extracurricular activities or social organizations? Yes No
If *Yes*, list:____

What are your child's favorite play activities when with friends?______________________

What are your child's favorite play activities when alone?___________________________

Are there any unusual or repetitive play activities?_________________________________

BEHAVIOR

Do you have any concerns regarding your child's behavior either at home, in public or at school?
Yes No
If *Yes*, please describe:____
____
____

Does your child display more anger and aggression compared to other children of his/her age?
Yes No
If *Yes,* please describe:____
____

Does your child display more sadness or irritability compared to other children of his/her age?
Yes No
If *Yes,* please describe:____
____

How do you handle discipline in your family?_____________________________________
____

Do you feel these methods are successful in managing your child's behavior? ___Yes ___No

Please share your child's strengths:____

____

____

What is your child's biggest accomplishment?____________________________________

MEDICAL INFORMATION/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), Anxiety or Depression? Yes No
If *Yes*, please specify:

____

Is the child on any medication at this time (circle)? Yes No
Please list Medication, Dosage, Times per day, Purpose, Condition, How long on medication, and Who prescribed?

____

____

____

____

____

Medical Treatment (Date of most recent medical exam):_______________________________

Pediatrician: ___________________________________ Phone_________________________________

Food or other allergies:____

Vision: Date of most recent vision exam:_______________________________________

Does your child have any vision problems: Yes No

If *Yes*, corrected with: Glasses or Contact lenses

Hearing Date of most recent hearing exam:_____________________________________

Does your child have any hearing problems: Yes No

If *Yes*, has it been treated? ____

Has your child ever had ear infections? Yes No

If *Yes*, age of first infection? ____

Total Number of infections before age 3:_______________________________________

Tubes? _________________________ Age? ______________________ Duration?______________

Has your child ever had speech problems? Yes No

If *Yes*, explain problem and treatment:____

____

Sensory Stimulation

Does your child display any unusual sensitivity to things (e.g., sound, light, touch, etc.)? Yes No

If *Yes,* please describe:____

Childhood Illness

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

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

Explain any of the above checked items and/or any other medical illnesses (please include age of child at the time of illness):____

____

____

____

Has this child ever been taken to the Emergency Room? Yes No

If *yes*, please list why and how old he/she was at the time of the visit

____

Does your child have any sleeping difficulties (trouble falling asleep, staying asleep, waking)

Yes No

If *Yes,* please describe:____

Does your child have any unusual eating patterns or habits? Yes No

If *Yes,* please describe:____

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

____

____

____

____

____