BACKGROUND QUESTIONNAIRE

Child's name _____ Today's date _____

Birthdate _____ Age _____ Sex: ☐ Male ☐ Female

Home address _____

_____

School _____ Teacher _____

Person(s) filling out this form: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Caregiver

☐ Other (please explain) _____

Mother's name _____ Age _____ Education _____

Occupation _____ Phone: Home _____ Business _____

Father's name _____ Age _____ Education _____

Occupation _____ Phone: Home _____ Business _____

Stepmother's name _____ Age _____ Education _____

Occupation _____ Phone: Home _____ Business _____

Stepfather's name _____ Age _____ Education _____

Occupation _____ Phone: Home _____ Business _____

Marital status of parents _____ If separated or divorced, how old was the child when the separation occurred? _____

If remarried, how old was the child when the stepparent entered the family? _____

List all people living in the household (please list additional people on a separate sheet if necessary):

Name	*Sex*	*Relationship to Child*	*Age*

List the name, sex, relationship to child, and age of any brothers, sisters, or other significant people living outside the home: _____

_____

_____

Dominant language spoken in the home _____ Other languages spoken in the home _____

What language does the child use to speak to you? _____

What language does the child use to speak with friends? _____

Was the child adopted? ☐ Yes ☐ No If yes, at what age? _____ Does the child know? ☐ Yes ☐ No

Name of medical coverage group or insurance company (If none, write "none") _____

Name of medical provider _____

If insured, insured's name _____

If referred, who referred you here? _____

PRESENTING PROBLEM

Briefly describe the child's current difficulties: _____

_____

_____

_____

How long has this problem been of concern to you? _____

When was the problem first noticed? _____

What seems to help the problem? _____

What seems to make the problem worse? _____

Have you noticed changes in the child's abilities? ☐ Yes ☐ No

If yes, please describe: _____

Have you noticed changes in the child's behavior? ☐ Yes ☐ No

If yes, please describe: _____

Has the child received evaluation or treatment for the current problem or similar problems? ☐ Yes ☐ No

If yes, when and with whom? _____

Is the child being treated for a medical illness? ☐ Yes ☐ No

If yes, for what condition is the child being treated? _____

Is the child on any medication at this time? ☐ Yes ☐ No

If yes, please note the kind of medication: _____

SOCIAL AND BEHAVIORAL CHECKLIST

Place a check next to any behavior or problem that the child *currently* exhibits.

- ☐ Has difficulty with hearing
- ☐ Has difficulty with vision
- ☐ Has difficulty with coordination
- ☐ Has difficulty with balance
- ☐ Has difficulty making friends
- ☐ Has difficulty keeping friends
- ☐ Refuses to share
- ☐ Prefers to be alone
- ☐ Does not get along well with brothers/sisters
- ☐ Does not get along well with adults
- ☐ Fights verbally with adults
- ☐ Fights physically with adults
- ☐ Yells and calls children names
- ☐ Shows wide mood swings
- ☐ Is aggressive (describe)

  _____
- ☐ Is withdrawn (describe)

  _____
- ☐ Is shy or timid
- ☐ Clings to others
- ☐ Tires easily, has little energy
- ☐ Is more interested in things (objects) than in people
- ☐ Engages in behavior that could be dangerous to self or others (describe)

  _____

  _____
- ☐ Breaks objects deliberately
- ☐ Lies (describe)

  _____
- ☐ Steals (describe)

  _____
- ☐ Injures self often
- ☐ Runs away
- ☐ Has low self-esteem
- ☐ Blames others for his or her troubles
- ☐ Is argumentative
- ☐ Does not get along well with other children
- ☐ Fights verbally with other children
- ☐ Fights physically with other children
- ☐ Does not show feelings
- ☐ Has frequent crying spells
- ☐ Has unusual or special fears, habits, or mannerisms (describe)

  _____
- ☐ Wets bed
- ☐ Bites nails
- ☐ Sucks thumb
- ☐ Has frequent temper tantrums
- ☐ Has trouble sleeping (describe)

  _____
- ☐ Rocks back and forth
- ☐ Bangs head
- ☐ Holds breath
- ☐ Eats poorly
- ☐ Is stubborn
- ☐ Has poor bowel control (soils self)
- ☐ Is much too active
- ☐ Is fidgety
- ☐ Is easily distracted
- ☐ Is disorganized
- ☐ Is clumsy
- ☐ Is unusually talkative
- ☐ Is forgetful
- ☐ Has blank spells
- ☐ Daydreams too much
- ☐ Worries a lot
- ☐ Is impulsive
- ☐ Takes unnecessary risks
- ☐ Gets hurt frequently
- ☐ Has too many accidents
- ☐ Doesn't learn from experience
- ☐ Feels that he or she is bad
- ☐ Is slow to learn
- ☐ Moves slowly
- ☐ Stares into space for long periods
- ☐ Engages in stereotyped behavior (describe) _____
- ☐ Does not understand other people's feelings
- ☐ Has difficulty following directions
- ☐ Gives up easily

(Continued)

- ☐ Complains of aches or pains
- ☐ Is disobedient
- ☐ Gets into trouble with the law
- ☐ Constantly seeks attention
- ☐ Is restless
- ☐ Has periods of confusion or disorientation
- ☐ Is jealous (describe) _____
- ☐ Is extremely selfish
- ☐ Feels hopeless
- ☐ Is nervous or anxious
- ☐ Is immature
- ☐ Is easily frustrated
- ☐ Has difficulty learning when there are distractors
- ☐ Is suspicious of other people
- ☐ Requires constant supervision
- ☐ Has difficulty resisting peer pressure
- ☐ Shows anger easily
- ☐ Has difficulty accepting criticism
- ☐ Feels sad or unhappy often
- ☐ Talks about wanting to die
- ☐ Has poor attention span
- ☐ Has poor memory
- ☐ Sets fires
- ☐ Is afraid of new situations
- ☐ Has trouble making plans
- ☐ Eats inedible objects
- ☐ Is not toilet trained
- ☐ Uses illegal drugs (describe) _____
- ☐ Drinks alcohol
- ☐ Other problems (describe) _____

Place a check next to any behavior or problem that the child has shown *within the last three months.*

- ☐ Shows sexually provocative behavior
- ☐ Has extreme fear of bathroom or bathing
- ☐ Has anxiety when separated from parents
- ☐ Has extreme anxiety about going to school
- ☐ Has fear at bedtime
- ☐ Is wary of any physical contact with adults in general
- ☐ Refuses to sleep alone
- ☐ Refuses to go to bed
- ☐ Has loss of bladder control
- ☐ Is fearful of strangers
- ☐ (In cases of divorce) Is fearful of visiting a parent or caregiver
- ☐ Overeats
- ☐ Is very eager to please others
- ☐ Refuses to undress for physical education classes at school
- ☐ Has compulsion about cleanliness—wanting to wash or feeling dirty all the time
- ☐ Appears dazed, drugged, or groggy upon return from visiting a divorced or separated parent
- ☐ Other recent behaviors or problems (describe) _____

LANGUAGE/SPEECH CHECKLIST

Place a check next to any language or speech problem that the child *currently* exhibits.

- ☐ Speaks in shorter sentences than expected for age
- ☐ Does not know names of common objects
- ☐ Has difficulty recalling familiar words
- ☐ Substitutes vague words (e.g., "thing") for specific words
- ☐ Responds better to gestures than to words
- ☐ Does not make appropriate gestures to communicate
- ☐ Uses gestures instead of words to express ideas
- ☐ Has difficulty making speech understood
- ☐ Speaks very slowly
- ☐ Speaks too fast
- ☐ Is often hoarse
- ☐ Has unusually loud speech
- ☐ Has unusually soft speech
- ☐ Makes sounds but no words
- ☐ Mixes up the order of events
- ☐ Seems uninterested in communicating
- ☐ Prefers to speak to adults only
- ☐ Prefers to speak to children only
- ☐ Prefers to speak to family members only
- ☐ Speaks in a monotone or exaggerated manner

EDUCATIONAL CHECKLIST

Place a check next to any educational problem that the child *currently* exhibits.

- ☐ Has difficulty with reading
- ☐ Has difficulty with arithmetic
- ☐ Has difficulty with spelling
- ☐ Has difficulty with handwriting
- ☐ Has difficulty with other subjects (please list) _____
- ☐ Has difficulty paying attention in class
- ☐ Has difficulty sitting still in class
- ☐ Has difficulty waiting turn in school
- ☐ Has difficulty taking notes in class
- ☐ Has difficulty respecting others' rights
- ☐ Has difficulty remembering things
- ☐ Forgets homework
- ☐ Has difficulty getting along with teacher
- ☐ Has difficulty getting along with other children
- ☐ Dislikes school
- ☐ Resists going to school
- ☐ Refuses to do homework

Did the child attend preschool? ☐ Yes ☐ No

If yes, at what ages? _____ How often? _____

At what age did the child begin kindergarten? _____ What is his or her current grade? _____

Is the child in a special education class? ☐ Yes ☐ No

If yes, what type of class? _____

(Continued)

Has the child been held back in a grade? ☐ Yes ☐ No

If yes, what grade and why? _____

Has the child ever received special tutoring or therapy in school? ☐ Yes ☐ No

If yes, please describe: _____

Has the child's school performance become poorer recently? ☐ Yes ☐ No

If yes, please describe: _____

Has the child missed a lot of school? ☐ Yes ☐ No

If yes, please indicate reasons: _____

DEVELOPMENTAL HISTORY

Pregnancy

Did the mother have any problems during pregnancy? ☐ Yes ☐ No ☐ Don't know

If yes, what kind? _____

How old was the mother when she became pregnant? _____ Was this a first pregnancy? ☐ Yes ☐ No

If no, how many times was the mother previously pregnant? _____

During pregnancy, did the mother smoke? ☐ Yes ☐ No ☐ Don't know

If yes, how many cigarettes each day? _____

During pregnancy, did the mother drink alcoholic beverages? ☐ Yes ☐ No ☐ Don't know

If yes, what did she drink? _____ Approximately how much alcohol was consumed each day? _____

During which part of pregnancy—1st trimester, 2nd trimester, 3rd trimester—was the alcohol consumed? _____

Were there times when 5 or more drinks were consumed? ☐ Yes ☐ No ☐ Don't know

If yes, during which trimester—1st trimester, 2nd trimester, 3rd trimester? _____

During pregnancy, did the mother use drugs (including prescription, over-the-counter, and recreational)? ☐ Yes ☐ No ☐ Don't know

If yes, what kind? _____

During pregnancy, was the mother exposed to any x-rays or chemicals? ☐ Yes ☐ No ☐ Don't know

If yes, what kind? _____

During pregnancy, was the mother exposed to any infectious disease? ☐ Yes ☐ No ☐ Don't know

If yes, what disease? _____

During pregnancy, did the mother receive prenatal care? ☐ Yes ☐ No ☐ Don't know

Was delivery induced? ☐ Yes ☐ No ☐ Don't know

How long was labor? _____ Were forceps used during delivery? ☐ Yes ☐ No ☐ Don't know

Was a cesarean section performed? ☐ Yes ☐ No ☐ Don't know

If yes, for what reason? _____

Were there any complications associated with the delivery? ☐ Yes ☐ No ☐ Don't know

If yes, what kind? _____

Was the child premature? ☐ Yes ☐ No ☐ Don't know

If yes, by how many weeks? _____

Was neonatal care needed? ☐ Yes ☐ No ☐ Don't know

If yes, what kind of care and how long was it needed? _____

(Continued)

Infancy

What was the child's birthweight? _____ Were there any birth defects or complications? ☐ Yes ☐ No

If yes, please describe: _____

Were there any feeding problems? ☐ Yes ☐ No

If yes, please describe: _____

Were there any sleeping problems? ☐ Yes ☐ No

If yes, please describe: _____

Were there any other problems? ☐ Yes ☐ No

If yes, please describe: _____

As an infant, was the child quiet? ☐ Yes ☐ No As an infant, did the child like to be held? ☐ Yes ☐ No

As an infant, was the child alert? ☐ Yes ☐ No As an infant, did the child grow normally? ☐ Yes ☐ No

If no, please describe: _____

As an infant, was the child different in any way from siblings? ☐ Yes ☐ No ☐ Not applicable

If yes, please describe: _____

First Years

During the child's first years, did he or she show any of the following behaviors? Place a check next to each one that he or she showed.

☐ Did not enjoy cuddling
☐ Was not calmed by being held
☐ Was colicky
☐ Was excessively restless
☐ Had poor sleep patterns
☐ Banged head frequently
☐ Was constantly into everything
☐ Had an excessive number of accidents
☐ Was exposed to lead
☐ Had fine-motor problems
☐ Had gross-motor problems
☐ Did not babble
☐ Did not speak
☐ Had excessive fears
☐ Ignored toys
☐ Was attached to an unusual object (describe) _____
☐ Was unaware of painful bumps or falls
☐ Had peculiar patterns of speech
☐ Preferred to play alone
☐ Had poor eye contact
☐ Was not interested in other children
☐ Did not smile socially
☐ Was insensitive to cold or pain
☐ Did not wave bye-bye

Were there any other special problems in the growth and development of the child during the first few years? ☐ Yes ☐ No

If yes, please describe: _____

The following is a list of infant and preschool behaviors. Please indicate the age at which the child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember or don't know the age at which the behavior occurred, please write a question mark. If the child has not yet demonstrated the behavior, write an X.

Behavior	*Age*	*Behavior*	*Age*	*Behavior*	*Age*
Showed response to mother	_____	Babbled	_____	Played pat-a-cake or peek-a-boo	_____
Held head erect	_____	Spoke first word	_____	Took off clothing alone	_____
Rolled over	_____	Showed fear of strangers	_____	Put on clothing alone	_____
Sat alone	_____	Put several words together	_____	Tied shoelaces	_____
Crawled	_____	Become toilet trained during day	_____	Rode tricycle	_____
Stood alone	_____	Stayed dry at night	_____	Named colors	_____
Walked alone	_____	Drank from cup	_____	Said alphabet in order	_____
Ran with good control	_____	Fed self	_____		

(Continued)

CHILD'S MEDICAL HISTORY

Place a check next to any illness or condition that the child has had. When you check an item, also note the approximate age of the child when he or she had the illness or condition.

Illness or condition	*Age*	*Illness or condition*	*Age*	*Illness or condition*	*Age*
☐ Measles	_____	☐ Seizures	_____	☐ Bone or joint disease	_____
☐ German measles	_____	☐ Broken bones	_____	☐ Gonorrhea or syphilis	_____
☐ Mumps	_____	☐ Hearing problems	_____	☐ Anemia	_____
☐ Chicken pox	_____	☐ Ear infections	_____	☐ Jaundice/hepatitis	_____
☐ Whooping cough	_____	☐ Seeing problems	_____	☐ Diabetes	_____
☐ Diphtheria	_____	☐ Fainting spells	_____	☐ Cancer	_____
☐ Polio	_____	☐ Loss of consciousness	_____	(list type) _____	
☐ Scarlet fever	_____	☐ Paralysis	_____	☐ High blood pressure	_____
☐ Meningitis	_____	☐ Dizziness	_____	☐ Heart disease	_____
☐ Encephalitis	_____	☐ Frequent headaches	_____	☐ Asthma	_____
☐ High fever	_____	☐ Difficulty concentrating	_____	☐ Bleeding problems	_____
☐ Convulsions	_____	☐ Memory problems	_____	☐ Eczema or hives	_____
☐ Allergies	_____	☐ Extreme tiredness	_____	☐ Suicide attempt(s)	_____
(please list) _____		☐ Rheumatic fever	_____	☐ Sleeping problems	_____
☐ Hay fever	_____	☐ Epilepsy	_____	☐ HIV	_____
☐ Injuries to head	_____	☐ Tuberculosis	_____	☐ AIDS	_____

Does the child have any disabilities? ☐ Yes ☐ No If yes, please describe: _____

Has the child had any serious illnesses? ☐ Yes ☐ No If yes, what illnesses? _____

Has the child been hospitalized? ☐ Yes ☐ No If yes, please list reasons: _____

Has the child had any operations? ☐ Yes ☐ No If yes, please list reasons: _____

Has the child had any accidents? ☐ Yes ☐ No If yes, please describe: _____

Are the child's immunizations up to date? ☐ Yes ☐ No Child's height _____ Child's weight _____

FAMILY MEDICAL HISTORY

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

	Relationship of family member to child		*Relationship of family member to child*
☐ Academic problem	_____	☐ Emotional problem	_____
☐ Alcoholism	_____	☐ Epilepsy	_____
☐ Cancer	_____	☐ Heart trouble	_____
☐ Depression	_____	☐ Neurological disease	_____
☐ Developmental problem	_____	☐ Suicide attempt	_____
☐ Diabetes	_____	☐ Other problems (please list)	_____
☐ Drug problem	_____		_____

(Continued)

OTHER INFORMATION

Child's Activities

What are the child's favorite activities?

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

What activities would the child like to engage in more often than he or she does at present?

1. _____ 2. _____ 3. _____

What activities does the child like least?

1. _____ 2. _____ 3. _____

What chores does the child do around the house? _____

Has there been any recent change in his or her ability to carry out these chores? ☐ Yes ☐ No

If yes, please describe the change: _____

What time does the child usually go to bed on weekdays? _____ On weekends? _____

Trouble with the Law

Has the child ever been in trouble with the law? ☐ Yes ☐ No

If yes, please describe briefly: _____

Referral to Child Protective Services or Similar Agency

Has the child ever been referred to Child Protective Services or another similar agency for having been maltreated? ☐ Yes ☐ No

If yes, please describe briefly: _____

Your Use of Disciplinary Techniques

Place a check next to each technique that you commonly use when the child behaves inappropriately. There also is space for writing in any other disciplinary techniques that you use.

- ☐ Ignore problem behavior
- ☐ Scold child
- ☐ Spank child
- ☐ Threaten child
- ☐ Reason with child
- ☐ Redirect child's interest
- ☐ Tell child to sit on chair
- ☐ Send child to his or her room
- ☐ Take away some activity or food
- ☐ Other technique (describe) _____
- ☐ Don't use any technique

Which disciplinary techniques are usually effective? _____

With what types of problems? _____

Which disciplinary techniques are usually ineffective? _____

With what types of problems? _____

Which parent (caregiver) usually administers discipline? _____

Activities Checklist

Place a check next to each activity that the child can do by himself or herself (even if the child does not do the activity regularly).

- ☐ Sets table
- ☐ Cooks meals
- ☐ Cleans table
- ☐ Washes dishes
- ☐ Helps with grocery shopping
- ☐ Unpacks groceries
- ☐ Does laundry
- ☐ Does ironing
- ☐ Puts clothes away
- ☐ Sews
- ☐ Empties garbage
- ☐ Does homework alone

(Continued)

Child's Responsibilities

Can the child be trusted to care for a pet? ☐ Yes ☐ No

If no, why not? _____

Does the child handle his or her personal finances? ☐ Yes ☐ No

If no, why not? _____

Does the child take responsibility for his or her personal hygiene? ☐ Yes ☐ No

If no, why not? _____

Is the child's behavior generally age appropriate? ☐ Yes ☐ No

If no, please describe in what ways it is not age appropriate: _____

_____

Other Areas

What do you enjoy doing with the child? _____

_____

What have you found to be the most satisfactory ways of helping the child? _____

_____

What are the child's assets or strengths? _____

_____

Is there any other information that you think may help us in working with the child? _____

_____

_____

_____

What prompted you to seek help at this time? _____

_____

Family Stress Survey

Every family sometimes experiences some form of stress. Please put a check next to each event that your family has experienced *in the last 12 months*. There also is a place for listing other types of stresses that your family experienced in the last 12 months.

- ☐ Child's mother died.
- ☐ Child's father died.
- ☐ Child's brother died.
- ☐ Child's sister died.
- ☐ Parents divorced.
- ☐ Parents separated.
- ☐ Grandparent died.
- ☐ Someone in family was seriously injured or became ill (list person): _____
- ☐ Parent remarried.
- ☐ Father lost job.
- ☐ Mother lost job.
- ☐ Family moved to another city.
- ☐ Family moved to another part of town.
- ☐ Someone in family was in trouble with the law or police (list person): _____
- ☐ Family's financial condition changed.
- ☐ Member of family was accused of child abuse or neglect (list person): _____
- ☐ Neighborhood was changing for the worse.
- ☐ Child was a victim of violence.
- ☐ Family experienced a natural disaster (list): _____
- ☐ Child started having trouble with parents (caregiver).
- ☐ Child started having trouble with sisters/brothers.
- ☐ Child started having trouble in school.
- ☐ Child changed schools.
- ☐ Child's close friend moved away.
- ☐ Child's pet died.
- ☐ Other types of stresses (list): _____

(Continued)

Parent Needs Survey[a]

Listed below are some needs commonly expressed by parents (caregivers). Please put a check next to each item if you need help in that area.

- ☐ More information about the child's abilities.
- ☐ Someone who can help me feel better about myself.
- ☐ Help with child care.
- ☐ More money/financial help.
- ☐ Someone who can babysit for a day or evening so that I can get away.
- ☐ Better medical care for the child.
- ☐ Better dental care for the child.
- ☐ More information about child development.
- ☐ More information about behavior problems.
- ☐ More information about programs that can help the child.
- ☐ Help communicating with the child's school.
- ☐ Someone to help with household chores.
- ☐ Counseling to help me cope with my situation.
- ☐ Better therapy services for the child.
- ☐ Day care so that I can get a job.
- ☐ A bigger or better house or apartment.
- ☐ More information about how I can help the child.
- ☐ More information about nutrition or feeding.
- ☐ Assistance in handling other children's jealousy of their brother or sister.
- ☐ Health insurance.
- ☐ Vocational training for me.
- ☐ Assistance in dealing with problems with in-laws or other relatives.
- ☐ Assistance in dealing with problems with friends or neighbors.
- ☐ Special equipment to meet the child's needs.
- ☐ Opportunities to meet people who have a child like mine.
- ☐ Someone to talk to about my problems.
- ☐ Assistance in dealing with problems with my husband/wife/partner.
- ☐ A car or other form of transportation.
- ☐ Medical care for myself.
- ☐ More time for myself.
- ☐ More time to be with the child.
- ☐ More time to be with my spouse/partner.
- ☐ More time to be with other adults.
- ☐ A vacation.
- ☐ Other needs (list)

_____
_____
_____
_____
_____
_____
_____
_____

Thank you.