FAMILY PSYCHOLOGICAL RESOURCES

Child's History

The following questions are asked so that we can best understand your child. Please fill out this questionnaire before the child is evaluated. Please read the questions carefully and answer them as fully as possible. Use the back of the sheet if necessary. If there are any questions you don't understand, they can be filled out with the examiner's help when he or she reviews the history with you. Please star (*) such questions.

Child's Information

Legal Name: _____ Birth Date:_____ Age:_____

Home Address:_____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Child's Doctor:_____ Phone:_____
What are the problems that caused you to seek help for this child? _____
_____
_____
_____

Family History

Child is living with: ❑ Both parents ❑ Mother ❑ Father ❑ Mother and Stepfather ❑ Father and Stepmother ❑ Legal Guardian ❑ Other (please specify)
Is the child adopted? ❑ Yes ❑ No If yes, with which parent(s) (if any) does the child live? ❑ natural ❑ adoptive Child's age at adoption:
Status of parents' marriage ❑ Married How long married?_____
❑ Separated ❑ Divorced How long divorced? _____ Child's age at divorce:_____
❑ Widowed ❑ Single

	Birth Mother	**Birth Father**
Age:	_____	_____
Highest grade completed:	_____	_____
Diploma/Degree:	_____	_____
Occupation:	_____	_____

Please describe any special education or tutoring:
_____ _____
_____ _____

Please describe any grades repeated or subjects failed:
_____ _____
_____ _____

Please describe any learning difficulty, and subject and grade level at which it occurred:
_____ _____

Please describe any behavior problems and treatment received:
_____ _____

Birth Mother **Birth Father**

Please describe any psychological or psychiatric problems for which treatment was received:

_____ _____

Any Attention-Deficit Disorder or hyperactivity? Please describe treatment:

_____ _____

Adoptive Mother/Stepmother/Other **Adoptive Father/Stepfather/Other**

(circle one) (circle one)

Age: _____ _____

Highest grade completed: _____ _____

Occupation: _____ _____

Other Children (including step-siblings and half-siblings)

Name Sex Age In home? School/behavioral/health problems

_____

_____

_____

_____

_____

Biological Extended Family

Do any extended family members (maternal/paternal grandparents, uncles, aunts, cousins) suffer from a problem with inattentiveness or hyperactivity; epilepsy; seizures; migraines; alcoholism or substance abuse; psychological, emotional, or personality difficulty; learning problems or developmental disabilities; and/or a "nervous" or neurological disorder; etc.?

❑Yes ❑No If yes, please list relationship to child, disorder, and any treatment received:

Maternal (mother's side) **Paternal (father's side)**

_____ _____

_____ _____

_____ _____

_____ _____

Please provide any other information about the child's extended family that might help us understand the child's needs (medical, developmental, behavioral, educational, emotional, or psychological). _____

_____

_____

Birth and Developmental History Pregnancy

Pregnancy

Length in months:_____

Any illnesses or complications while pregnant? ❑Yes ❑No If yes, please explain: _____

_____

Medications taken by the mother during pregnancy? _____

Substances used during pregnancy: _____
❑ Cigarettes How many? _____per (❑day ❑ week)
❑ Alcohol How many drinks? ____ per (❑ day ❑ week ❑ month)
❑ Drugs Please describe type(s) of drug, frequency of use, and at what month of pregnancy use was stopped (if applicable):_____
_____
Was the father taking any medications or drugs at time of conception? ❑ Yes ❑ No If so, what?_____
_____
How many pregnancies and/or miscarriages has the mother had?_____

Labor and Delivery

Was the birth of the child "normal"? ❑ Yes ❑ No If no, please explain:_____
_____

Do you think the child's problems might be related to pregnancy, labor, or delivery?
❑ Yes ❑ No If yes, please explain:_____
_____
_____

Perinatal History

Birth weight_____ Length _____ APGAR scores _____
Did mother or baby stay in Special or Intensive Care? ❑ Yes ❑ No
Please describe any problems: _____
_____
_____
Please list any birth defects: _____
_____
_____

Medical History
Has the child been taken to the emergency room with a serious emergency, hospitalized, or had outpatient surgery since birth? ❑ Yes ❑ No If yes, please describe condition/injury, treatment, any surgery, when, how long, and where: _____
_____
_____
_____

If the child had a head injury: Did he or she lose consciousness? ❑ Yes ❑ No
If yes, how long? _____
Was he or she comatose? ❑ Yes ❑ No If yes, how long? _____
Do you see the child as being ❑ hyperactive? ❑ inattentive ❑ a behavior problem?
Does the child seem to be able to control his or her behavior and attention?
❑ Yes ❑ No If no, please explain: _____
Has the child ever been diagnosed by a psychologist, physician, or other professional as having ADHD (Attention-Deficit/ Hyperactivity Disorder) ❑ Yes ❑ No

If yes, when? _____
What treatment has the child had for ADHD (other than medications)? _____
_____
_____

What medication(s) has the child received for ADHD (include dosage and times)? _____
_____
_____

Please describe any other handicapping conditions or special health considerations and their treatments:_____
_____

Date of last hearing test: _____ Were the results normal? ❑ Yes ❑ No
If no, please explain: _____
_____

Date of last vision test: _____Does the child wear ❑ Glasses? ❑ Contacts?
Why? _____

Please list medications currently being taken by the child, including nonprescription medications (with dosage and times): _____
_____
_____

The child's current health is: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

Infancy And Early Childhood

Please rate the child on the following behaviors: Circle 1 if the behavior on the left was present the majority of the time. Circle 5 if the behavior on the right was present the majority of the time. Stages in between are represented by 2, 3, and 4. If there are two behaviors listed (e.g., tantrums and head banging), please check the one that was present.

quiet and content	1	2	3	4	5	colicky and irritable
very easy to feed	1	2	3	4	5	daily feeding problems
slept well	1	2	3	4	5	frequent sleeping problems
usually relaxed	1	2	3	4	5	often restless
underactive	1	2	3	4	5	overactive
cuddly, easy to hold	1	2	3	4	5	did not enjoy cuddling
easily calmed down	1	2	3	4	5	❑tantrums ❑head banging
cautious and careful	1	2	3	4	5	❑accident prone ❑daredevil
coordinated	1	2	3	4	5	uncoordinated
enjoyed eye contact	1	2	3	4	5	avoided eye contact
liked people	1	2	3	4	5	disliked contact with people

Other problems or comments regarding infancy or early childhood development: _____
_____

Did any event, health condition, separation, etc., disturb early infant/mother bonding or the developing toddler/mother relationship? ❑ Yes ❑ No If yes, please explain: _____
_____

Please describe the child as an infant (temperament, sleeping, eating patterns, etc.): _____
_____
_____
_____
_____

Ages at Milestones

Gross Motor Skill	**Age**	**Language Skill**	**Age**
Crawled	_____	used single words	_____
Walked alone	_____	used sentences (2+ words)	_____
Ran well	_____	described activity	_____
Fine Motor Skill	**Age**	**Social/Adaptive Skill**	**Age**
Fed self with spoon	_____	potty trained/day	_____
Scribbled	_____	potty trained/night	_____
Tied shoe	_____		

Rate of development overall: ❑ Slow ❑ Normal ❑ Fast

Behavioral and Mental Health History

Please describe any behaviors that are particularly concerning to you or others: _____
_____
_____

Please list any unusual, traumatic, or possibly stressful events in the child's life that you think may have had an impact on his or her development and current functioning. Include incident, child's age at the time and comments: _____
_____
_____

Has the child or family received any professional mental health treatment, such as individual or family counseling, group counseling, etc.? ❑Yes ❑ No If yes, please list any past and current treatments, including type of counseling, person counseled, name of counselor, and length of treatment: _____
_____
_____

Present Personality and Behavior

Please circle all traits that apply to the child now:

Sad	Happy	Leader
Follower	Moody	Friendly
Quiet	Overactive	Independent
Dependent	Sensitive	Affectionate
Fearful	Cooperative	Tantrums
Lethargic	Too responsible	Trouble sleeping
Hard to discipline	Even-tempered	Prefers to be alone

Educational History

Did the child attend preschool or daycare? If so, list location, type of program, number of days per week, age when started, and progress:_____
_____
_____

Current grade and school: _____
List previous schools and grades attended at each:_____
_____
_____

Briefly describe the child's performance and any concerns in each grade:
Kindergarten: _____
1st grade: _____
2nd grade: _____
3rd grade: _____
4th grade: _____
5th grade: _____
Middle School:_____

Has the child been placed in special education programs currently or in the past?
❑ Yes ❑ No If yes, please describe:
Category: _____

❑ Learning Disability (LD): _____
(subjects)

❑ Language Disorder: _____
(type)

❑ Tutoring: _____
(subjects)

Additional Information

Please attach results of any previous testing.
Please add any additional comments you think might be helpful.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature _____ Date:_____
Individual completing form, relationship to child